

School-Based Services

*Medicaid and Other Medical
Assistance Programs*



February 2007

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My Medicaid Provider ID Number:
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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated “In state” will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, PASSPORT, payments, denials, general claims questions, or to request provider manuals or fee schedules:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims and adjustment requests to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Restricted Client Authorization

For authorization for emergency services provided for restricted clients, contact the Surveillance/Utilization Review Section:

(406) 444-4167

All other services must be authorized by the client’s designated provider.

Client Help Line

Clients who have general Medicaid or PASSPORT questions may call the Client Help Line:

(800) 362-8312

Send written inquiries to:

PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

Provider Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the *General Information For Providers* manual.

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

CSCT Program

For more information on the Comprehensive School and Community Treatment (CSCT) program, contact the school-based program specialist or the Children's Mental Health Bureau.

(406) 444-4540 Phone

(406) 444-1861 Fax

Send written inquiries to:

School-Based Program Specialist or
Children's Mental Health Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

For inquiries related to licensure/endorsement, contact the Quality Assurance Division, licensing Bureau:

(406) 444-2676 Phone

(406) 444-1742 Fax

Send written inquiries to:

Quality Assurance Division
Licensing Bureau
2401 Colonial Drive, Third Floor
Helena, MT 59602-2693

CHIP Program

(877) 543-7669 Phone toll-free in and out-of-state

(406) 444-6971 Phone in Helena

(406) 444-4533 Fax In Helena

(877) 418-4533 Fax Toll-free in and out-of-state

chip@state.mt.us E-mail

CHIP Program Officer
P.O. Box 202951
Helena, MT 59620-2951

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

Chemical Dependency Bureau

For coverage information and other details regarding chemical dependency treatment, write or call:

(406) 444-3964 Phone

Send written inquiries to:

Chemical Dependency Bureau
Addictive and Mental Disorders Division
DPHHS
P.O. Box 202905
Helena, MT 59620-2905

Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

Mountain-Pacific Quality Health Foundation

For questions regarding prior authorization for transplant services, private duty nursing services, medical necessity therapy reviews, and emergency department reviews:

Phone:

(800) 262-1545 X150 In state

(406) 443-4020 X150 Out of state and Helena

Fax:

(800) 497-8235 In state

(406) 443-4585 Out of state and Helena

Send written inquiries to:

Mountain-Pacific Quality
Health Foundation
3404 Cooney Drive
Helena, MT 59602

Prior Authorization (continued)

First Health

For questions regarding prior authorization and continued stay review for selected mental health services.

(800) 770-3084 Phone

(800) 639-8982 Fax

(800) 247-3844 Fax

First Health Services
4300 Cox Road
Glen Allen, VA 23060

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone

(406) 444-1861 Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

(406) 444-4540 Phone

(406) 444-1861 Fax

Nurse First Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Key Web Sites	
Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsdp.dphhs.mt.gov	Select <i>Human Services</i> for the following information: <ul style="list-style-type: none"> • Medicaid: Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information and a link to the Provider Information Website. • Senior and Long Term Care: Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • DPHHS: Latest news and events, DPHHS information, services available, and legal information.
Provider Information Website www.mtmedicaid.org or www.dphhs.mt.gov/hpsd/medicaid/medicaid2	<ul style="list-style-type: none"> • Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
CHIP Website www.chip.mt.gov	<ul style="list-style-type: none"> • Information on the Children's Health Insurance Plan (CHIP)
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: <ul style="list-style-type: none"> • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
Washington Publishing Company www.wpc-edi.com	<ul style="list-style-type: none"> • EDI implementation guides • HIPAA implementation guides and other tools • EDI education

Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for the school-based services program.

Each chapter has a section titled *Other Programs* that includes information about other Department programs such as the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP). Other essential information for providers is contained in the separate *General Information For Providers* manual. Each provider is asked to review both the general manual and the specific manual for his or her provider type.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of *Key Contacts* at the beginning of each manual. We have also included a space on the back side of the front cover to record your Medicaid Provider ID number for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages. When replacing a page in a manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy. Notices and replacement pages are available on the Provider Information website (see *Key Contacts*).

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rule references are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office



Providers are responsible for knowing and following current laws and regulations.

(see *Key Contacts*). The following rules and regulations are specific to the school based services program. Additional Medicaid rule references are available in the *General Information For Providers manual*.

- Administrative Rules of Montana (ARM)
 - ARM 37.86.2201 EPSDT Purpose, Eligibility and Scope
 - ARM 37.86.2206 - 2207 EPSDT Medical and Other Services; Reimbursement
 - ARM 37.86.2217 EPSDT Private Duty Nursing
 - ARM 37.86.2224-2233 EPSDT, CSCT and Health Related Services

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information For Providers manual* also has a list of contacts for specific program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Contacts*).

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid provider's claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Program Overview

Title XIX of the Social Security Act provides for a program of medical assistance to certain individuals and families with low income. This program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the federal and state governments. Federal oversight for the Medicaid program lies with the Centers for Medicare and Medicaid Services (CMS) in the Department of Public Health and Human Services (DPHHS).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a special program for Medicaid beneficiaries under 21 years of age. The purpose of EPSDT is to ensure that through periodic check ups and early detection, children's health problems are prevented and/or ameliorated. The EPSDT program allows states to provide services even if these services are not covered under the Medicaid state plan for other beneficiaries.

The Medicare Catastrophic Coverage Act, enacted in 1988, contained provisions which permit state Medicaid programs to provide reimbursement for health-related services provided as part of a child's Individualized Education Plan (IEP). This reversed a previous policy that Medicaid could not reimburse for services provided by schools. As a result of this act, the State of Montana allows schools and cooperatives to bill for Medicaid services provided to Medicaid clients pursuant to an IEP.

Medicaid reimburses health-related services provided by schools that are written into an IEP, if the services are covered under the Medicaid state plan or are covered under EPSDT. Services billed to Medicaid must be provided by qualified practitioners with credentials meeting state and federal Medicaid program requirements. Medicaid provides reimbursement for health-related services and does not reimburse for services that are educational or instructional in nature.

Medicaid can be an important source of funding for schools, particularly because the cost of providing special education can greatly exceed the federal assistance provided under the Individuals with Disabilities Education Act (IDEA). Children who qualify for IDEA are frequently eligible for Medicaid services. Although Medicaid is traditionally the "payer of last resort" for health care services, it is required to reimburse for IDEA related medically necessary services for eligible children before IDEA funds are used.

In Montana, the Department of Public Health & Human Services, Medicaid Services Bureau, administers the Medicaid School-Based Services Program. This guide contains specific technical information about program requirements associated with seeking payment for covered services rendered in a school setting. The purpose of this guide is to inform schools on the appropriate methods for claiming reimbursement for the costs of health-related services provided.

Covered Services

General Coverage Principles

Medicaid covers health-related services provided to children in a school setting when all of the following are met:

- The child qualifies for Individuals with Disabilities Education Act (IDEA)
- The services are written into an Individual Education Plan (IEP)
- The services are not free. Providers may not bill Medicaid for any services that are generally offered to all clients without charge
- For CSCT services, children must have a serious emotional disturbance (SED) diagnosis as specified under ARM 37.86.3702(2).

Refer to the IEP requirements in this chapter and the Coordination of Benefits chapter regarding billing services included/not included in a child's IEP.

This chapter provides covered services information that applies specifically to school-based services. School-based services providers must meet the Medicaid provider qualifications established by the state and have a provider agreement with the state. These providers must also meet the requirements specified in the *School-Based Services* manual and the *General Information For Providers* manual. School-based services provided to Medicaid clients include the following:

- Therapy services (physical therapy, occupational therapy, speech language pathology)
- Audiology
- Private duty nursing
- School psychology and mental health services (including clinical social work and clinical professional counseling)
- Comprehensive School and Community Treatment (CSCT)
- Personal care (provided by paraprofessionals)
- Other diagnostic, preventative and rehabilitative services
- Specialized transportation

Services for children (ARM 37.86.2201 – 2221)

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all school-based services described in this manual. All applicable PASSPORT To Health and prior authorization requirements apply (see the *PASSPORT and Prior Authorization* chapter in this manual).

Services within scope of practice (ARM 37.85.401)

Services provided under the school-based services program are covered only when they are within the scope of the provider's license.

Provider requirements

Most school-based services must be provided by licensed health care providers. The exception is that activities of daily living services may be provided by personal care paraprofessionals. Medicaid does not cover services provided by a teacher or teacher's aide; however, teachers or teacher aides may be used to assist in the development of child care planning. School-based services must be provided by only those providers listed in the table below.

Provider Type	Provider Requirements
Private duty nursing services provided by: <ul style="list-style-type: none"> Licensed registered nurse Licensed practical nurse 	Nurses must have a valid certificate of registration issued by the Board of Nurse Examiners of the State of Montana or the Montana Board of Nursing Education and Nurse Registration.
Mental health services provided by: <ul style="list-style-type: none"> Credentialed school psychologist Licensed psychologist Licensed clinical professional counselor Licensed clinical social worker 	Mental health providers must be licensed according to Montana's state requirements. School psychologist services are provided by a professional with a Class 6 specialist license with a school psychologist endorsement.
Therapy services provided by: <ul style="list-style-type: none"> Licensed occupational therapist Licensed physical therapist Licensed speech language pathologists 	These therapists are required to meet appropriate credentialing requirements as defined by the Montana Licensing Board.
Audiology	Must meet credentialing requirements as defined by the Montana Licensing Board
Personal care paraprofessional	No licensing requirements
Comprehensive School & Community Treatment (CSCT)	Must be provided by a licensed mental health center with a CSCT endorsement

It is the responsibility of the school district to assure appropriately licensed providers perform all Medicaid covered services. Each school district must maintain documentation of each rendering practitioner's license, certification, registration or credential to practice in Montana. Medicaid providers who have had their license suspended by a state or federal government entity may not provide school-based services.

IEP requirements

Services provided to Medicaid clients must be covered by Medicaid and documented in the client's Individualized Education Plan (IEP), unless otherwise specified. School-based providers may bill Medicaid for Medicaid-covered health-related services provided to children with those services written into the

Services provided to Medicaid clients must be documented in the client's IEP.

IEP, even though the services may be provided to non-Medicaid children for free. However, if a child is covered by both Medicaid and private insurance, the private insurance must be billed prior to Medicaid. Exception to billing other insurance: BC/BS of Montana and CHIP.

Medicaid does not cover health-related services that are not included in an IEP unless all of the following requirements are met:

- Youth is enrolled in Medicaid
- Services are medically necessary
- A fee schedule is established for health-related services (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

Client qualifications

To qualify for Medicaid school-based services, the client must be a Medicaid client and meet all the following criteria:

- Be Medicaid eligible on the date of service
- Be between the ages 3 and 20
- Be entitled to school district services under the Individuals with Disabilities Education Act (IDEA)
- Have Medicaid reimbursable services referenced in his or her Individual Educational Plan (IEP). This shows that Medicaid covered services are recommended by the school district.
- In the case of CSCT services, the client must have an SED diagnosis and services may or may not be included in the client's IEP.

School qualifications

Only public school districts, full-service education cooperatives and joint boards of trustees may enroll in the Montana Medicaid school-based services program. To qualify, the district, cooperative or joint board must receive special education funding from the state's Office of Public Instruction general fund for public education. School districts include elementary, high school and K-12 districts that provide public educational services. Full-service education cooperatives and joint boards include those cooperatives eligible to receive direct state aid payments from the Superintendent of Public Instruction for special education services.

Schools that employ medical service providers

- Schools who employ all or most of their medical service providers for whom the school submits bills can be enrolled with a single provider number for all services.



Cooperatives, joint boards, and non-public schools that do not receive state general funds for special education can not participate in the Medicaid program as a school-based provider.

- Schools may use this single provider number to bill for any Medicaid covered service provided by a licensed provider.
- Schools that wish to have separate provider numbers for each provider type (e.g., speech therapists, occupational therapists, and physical therapists) can request separate provider numbers from Provider Enrollment (see *Key Contacts*).

Schools that contract with external medical service providers

- Schools that contract with all or most of their medical service providers for whom the school submits bills cannot be enrolled with a single provider number.
- Schools that contract with all or most of their providers must have the provider of service bill for each service they provide with their own individual Medicaid provider number.
- Providers and schools can arrange with the Department for payments to be made to the school. If payments are assigned to the school, the school will also have the responsibility to collect third party liability payments on behalf of the service providers.

For more information on enrollment, visit the Provider Information website or contact Provider Enrollment (see *Key Contacts*).

Physician order/referral

Medicaid does not require physician orders or referrals for health-related services that are documented in the client's IEP. The exception is private duty nursing services and personal care assistant services, which require **both** a written order and PASSPORT approval. Other health-related services can be authorized by a licensed school practitioner meeting the State of Montana provider requirements to secure health-related services under an IEP. For instructions on getting PASSPORT approval, see the *PASSPORT and Prior Authorization* chapter in this manual. See the table of authorization requirements later in this chapter.

Documentation requirements

School-based services providers must maintain appropriate records. All case records must be current and available upon request. Records can be stored in any readily accessible format and location, and must be kept for six years and three months from the date of service. For more information on record keeping requirements, see the *Surveillance/Utilization Review* chapter in the *General Information For Providers* manual. Medical documentation must include the following:

- Keep legible records!
- Date of service and the child's name
- The service(s) provided during the course of each treatment and how the child responded.
- Except for CSCT, the services for which the school is billing Medicaid must be written into the child's IEP.

- If the service is based on time units, (i.e. 15 minutes per unit), the provider of service should indicate begin and end times or the amount of time spent for each service. A service must take at least eight minutes to bill one unit of service if the procedure has “per 15-minutes” in its description.
- Providers must sign and date each record documented on the day the medical service was rendered. Provider initials on daily records are acceptable providing their signature is included in other medical documentation within the child’s record.
- Documentation must, at least quarterly, include notes on client progress towards their goals.
- The service provider must keep sufficient documentation to support the procedure(s) billed to Medicaid. If a service is not documented, it did not happen.
- Documentation must not be created retroactively. Providers are responsible for maintaining records at the time of service.
- CSCT services are not required to be included in the IEP because often clients that require these services do not fit the special education requirements. The clinical assessment must document the medical necessity and the clinical treatment plan must demonstrate how the CSCT services will address the medical necessity. In addition to the above requirements, CSCT documentation must also include:
 - Where services were provided;
 - Result of service and how service relates to the treatment plan and goals;
 - Progress notes for each individual therapy and other direct service;
 - Monthly overall progress notes;
 - Individual outcomes compared to baseline measures and established benchmarks.

The Montana Medicaid School-Based Services Program is subject to both state and federal audits. As the Medicaid provider, the school certifies that the services being claimed for Medicaid reimbursement are medically necessary and furnished under the provider’s direction. Both fiscal and clinical compliance are monitored. In the event of adverse findings, the district/cooperative (not the mental health provider) will be held responsible for any paybacks to Medicaid. If school districts have included a program area for CSCT in their accounting system, then the district can book revenue received from third party insurers or parents that paid privately for CSCT services, providing audit documentation (see the *Comprehensive School and Community Treatment* section in this chapter). To assist in document retention for audit purposes, see the *Audit Preparation Checklist* in *Appendix A: Forms*.

Non-covered services (ARM 37.85.207 and 37.86.3002)

The following is a list of services not covered by Medicaid.

- A provider's time while attending client care meetings, Individual Educational Plan (IEP) meetings, individual treatment plan meetings, or client-related meetings with other medical professionals or family members
- A provider's time while completing IEP related paperwork or reports, writing the CSCT individualized treatment plans or documenting medical services provided
- CSCT services provided without an individualized treatment plan for this service
- Services considered experimental or investigational
- Services that are educational or instructional in nature
- Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment.

Importance of fee schedules

The easiest way to verify coverage for a specific service is to check the Department's school-based services fee schedule. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service. Current fee schedules are available on the Provider Information website (see *Key Contacts*). For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Coverage of Specific Services

The following are coverage rules for specific school-based services.

Assessment to initiate an IEP

Medicaid covers medical evaluations (assessments) to develop an IEP as long as an IEP is subsequently established and health-related needs are identified.

Comprehensive School and Community Treatment (CSCT)

Comprehensive School and Community Treatment (CSCT) is a very intense service designed for youth who are in immediate danger of out-of-home placement and/or exclusion from school or community. CSCT provides a comprehensive, planned course of outpatient treatment provided primarily in the school to a child with a serious emotional disturbance (SED). These services are provided through a program operated by a public school district that is a licensed mental health center or a school district that has a contract with a licensed mental health center. CSCT services include, among other services, individual, group and family therapy and behavioral interventions.

Use the current fee schedule for your provider type to verify coverage for specific services.

The CSCT Program must follow *free care rules* (see *Definitions*).

CSCT requirements

A licensed mental health center must have a CSCT endorsement issued by the Quality Assurance Division, Licensing Bureau. For more information on how to apply for program endorsement, contact the Montana Department of Public Health and Human Services (see *CSCT Program* in *Key Contacts*). For information on CSCT Program requirements, see *Appendix C: CSCT Program*.

- ***Services provided by a Mental Health Center.*** Services under the CSCT program must be provided by a school that is a licensed mental health center or a licensed mental health center that has contracted with the schools. Schools are required to lead the program management and are specifically required to meet all of the requirements described in this chapter.
- ***Program endorsed before providing services.*** Program endorsement must be obtained by the licensed mental health center prior to the service implementation in order for school districts or cooperatives to implement CSCT programs.
- ***Program staff requirements.*** Program staff must include at least two mental health workers and one of the two mental health workers must be a licensed psychologist, licensed clinical social worker, licensed professional counselor or in-training mental health professional (ARM 37.88.901). The Department of Public Health and Human Services must approve an in-training mental health professional prior to program approval, but approval is not required for licensed providers.
- ***Children must have serious emotional disturbances*** (ARM 37.86.3702(2)). The CSCT program is intended specifically for children who have serious emotional disturbances, regardless of whether the child is eligible for special education services. This program is not intended for children with functional limitations who require support for activities of daily living (ADL). Children that require ADL support are covered by other Medicaid services like personal care paraprofessionals.
- ***Services must be medically necessary*** (ARM 37.82.102 and 37.85.410). CSCT services must be medically necessary. See *medically necessary* in the *Definitions* section of this manual. Medicaid considers experimental services or services which are generally regarded by the medical profession as unacceptable treatment not medically necessary.
- ***Services must be available to all qualifying children.*** CSCT services must be made available to all children that meet criteria for those services, not just because the child has Medicaid benefits. In the case of school-based programs that provide services to children

that do not have IEPs, Medicaid will pay for covered services if the following are in place:

- A fee schedule is established (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

The exception to this policy is the services that are provided to Medicaid eligible children and the services are written into the children's IEPs (see *IEP Requirements* in this chapter).

- ***Program must follow free care rule.*** Everyone who receives CSCT services must be billed for the services. If a service is free for non-Medicaid clients, then it is free for all children. Medicaid billable services provided under an IEP are not subject to the *free care rule* (see *IEP Requirements* in this chapter).

Services included

Strategies, coordination and quality improvement activities related to the individual child's treatment plans are included in the CSCT program in addition to the following services:

- Individual, family and group therapy
- Behavior intervention
- Crisis intervention services
- Coordination with other addictive and mental health treatment services the child receives outside the CSCT program
- Other evidence and research-based practices effective in the treatment of children or adolescents with SED
- Access to emergency services
- Referral and aftercare coordination with inpatient facilities, residential treatment programs or other appropriate out of home placement programs
- Continued treatment that includes services during non-school days integrated in a manner consistent with the child or adolescent's treatment plan.

Service requirements

The CSCT program must be provided through a program of services staffed by at least two mental health workers who work exclusively in the school. At least one of the two mental health workers must be a licensed psychologist, licensed clinical social worker, licensed professional counse-

lor, or a DPHHS approved in-training mental health professional. The minimum staffing requirement for a program is one team with the capacity to provide up to 720 units per calendar month to children with SED. Part-time staff may be utilized but the billing units must be reduced proportionately.

- *Caseload* refers to the total number of units the CSCT program team may provide in a calendar month. Ideally the staff and CSCT clients should be all contained in one school. It is acceptable, however, for a CSCT program team to provide up to 720 units to be spread across no more than two schools located in close proximity of one another. Coverage by a CSCT team of more than two school campuses is not acceptable.
- The expectation is that the full-time CSCT staff will be available throughout each day to meet the needs of the CSCT clients. It is not generally appropriate, therefore, for the licensed or in-training mental health professional CSCT worker to have an outpatient caseload in addition to CSCT duties. The only exception is youth transitioning out of CSCT who need some therapeutic support.
- The use of an “in-training mental health professional” in a CSCT program is allowed on an infrequent and exceptional basis. It is recognized that recruitment of licensed professionals may be difficult in some parts of the state. Approval for such an arrangement must be obtained from the Children’s Mental Health Bureau in writing. In its request to use an in-training mental health professional the CSCT program must document the following:
 - The program has advertised for a licensed professional unsuccessfully in newspapers and through Job Service for at least three weeks. The program must have offered a salary that is competitive for the community in which the program is located. The Department will not approve the use of an in-training mental health professional unless a salary of at least state pay plan grade 15, entry level plus benefits including health insurance, has been offered during the unsuccessful recruitment.
 - The in-training mental health professional has completed all academic work required for the license and has begun the post-degree supervised experience required for licensure.
 - A licensed professional has entered into a written agreement to provide supervision of the post degree experience required for licensure.
 - A licensure examination date (or at least an approximate date) has been selected.
 - The in-training mental health professional may serve in lieu of a licensed CSCT staff for no more than 2 years.

- The in-training mental health professional has had relevant prior experience serving SED children.
- The CSCT program offers, at a minimum, face-to-face supervision by a licensed professional that meets the appropriate discipline licensing standard, at the CSCT site.
- CSCT services must also be available for non-Medicaid clients who meet the CSCT program requirements. In addition to providing these services, districts/cooperatives must also request payment for these services. Services may be billed based on a sliding fee schedule to non-Medicaid children. Schools may contract with their CSCT provider to bill Medicaid, private-pay patients and insurance carriers.
- CSCT services not specified in the IEP must be made available and billed to **all** children who receive services.
- Providers may not bill Medicaid for any CSCT services that are generally offered to all clients without charge.
- CSCT services do not require PASSPORT approval or inclusion in the child's IEP.
- CSCT services must be provided according to an individualized treatment plan. The treatment plan must be reviewed and approved by a licensed professional who is a CSCT staff member.

Billable Services

- Face to face service
 - Individual
 - Family
 - Group
 - Behavioral interventions

Services restricted

Medicaid does not cover the following services under the CSCT program:

- Observation and monitoring/supervision
- Non-face to face service
- Time in meetings
- More than 720 units of service per CSCT team per calendar month
- Prior authorization is required for outpatient therapy services provided concurrently or outside the CSCT program.
- Educational assistance or assisting with homework
- Watching movies

Therapy services

Therapy includes speech, occupational and physical therapy services. Services may be performed by a therapy assistant or therapy aide but must be billed to Medicaid under the school's supervising licensed therapist's Medicaid provider number (see the *Billing Procedures* chapter in this manual).

The levels of supervision are as follows:

- General: Procedure is furnished under the licensed provider's direction and control, but the licensed provider's presence is not required during the performance of the procedure.
- Direct: The licensed provider must be present in the office and immediately available to furnish assistance and direction throughout the performance of the procedure. The licensed provider must be in the direct treatment area of the client-related procedure being performed.
- Routine: The licensed provider must provide direct contact at least daily at the site of work, within interim supervision occurring by other methods, such as telephonic, electronic or written communication.
- Temporary Practice Permit holders (new grads from occupational therapy school who are waiting for their national exam results) **MUST** work under ROUTINE supervision of the licensed therapist. If the exam is failed the Temporary Practice Permit **IMMEDIATELY** becomes VOID. Routine supervision requires direct contact at least daily at the site of work.
- Occupational and Speech Therapy Aides require personal, direct supervision by the licensed provider. This means the licensed provider must be face to face with the aide in the same room when procedures are being provided.
- Speech Therapy Aides:
 - Aide 1 = supervised a minimum of 30% while performing diagnostic and interpretive functions in the first year of non-allowable activities. The supervision requirement will be 5% of client contact time, of which 2% shall be direct contact after the first year, at the discretion of the supervising speech-language pathologist
 - Aide 2 = shall be supervised 10% of client contact time, of which 5% shall be direct contact
 - Aide 3 = shall be supervised 20% of client contact time, of which 5% shall be direct contact. Refer to ARM 24.222.702
- Occupational Therapy Assistants require general supervision, meaning the licensed provider does not have to be physically on the premises at the time of the service. However, the licensed therapist must provide face to face supervision at least monthly.
- Physical Therapy Aides/Assistants require general supervision, meaning that the licensed provider must be on the premises.
- Temporarily licensed therapists can never supervise anyone.

Services included

Covered therapy services include the following:

- Restorative therapy services when the particular services are reasonable and necessary to the treatment of the client's condition and subsequent improvement of function. The amount and frequency of services provided must be indicated on the client's IEP.
- Assessment services to determine client medical needs and/or to establish an IEP, as long as the assessment results in health-related services documented in the IEP.

Service requirements

For clients who are enrolled in the PASSPORT To Health program, the client's PASSPORT provider's approval is required before providing therapy services. For instructions on receiving PASSPORT approval, see the *PASSPORT and Prior Authorization* chapter in this manual.

Services restricted

- Montana Medicaid does not cover therapy services that are intended to maintain a client's current condition but only covers services to improve client functions.
- Therapy services are limited to 40 hours per state fiscal year (July 1 - June 30) for each type of therapy. This limit may be exceeded if the client is still progressing in his or her treatment.

Private duty nursing services

Private duty nursing services are skilled nursing services provided by a registered or licensed practical nurse.

Service requirements

Medicaid covers private duty nursing services when all of the following requirements are met:

- When the client's attending physician or mid-level practitioner orders these services in writing
- When the client's PASSPORT provider or primary care provider approves the service (see the *PASSPORT and Prior Authorization* chapter in this manual)
- When prior authorization (PA) is obtained (see the *PASSPORT and Prior Authorization* chapter in this manual for PA requirements)

School psychologists and mental health services

Psychological services in schools are based on determining eligibility for inclusion in special education programming and not necessarily to determine a medical diagnosis outside of the guidelines of the Individuals with Disabilities Education Act.

Services included

Psychological and mental health services include the following:

- Individual psychological therapy
- Psychological tests and other assessment procedures when the assessment results in health-related services being written into the IEP
- Interpreting assessment results
- Obtaining, integrating and interpreting information about child behavior and conditions as it affects learning, if it results in an IEP. This only includes direct face-to-face service.
- Mental health and counseling services that are documented on the client's IEP
- Consultation with the child's parent as part of the child's treatment

Service requirements

Medicaid covers psychological counseling services when the following two criteria are met:

- The client's IEP includes a behavior management plan that documents the need for the services
- Service is not provided concurrently with CSCT services (unless prior authorization has been obtained).

Services restricted

Montana Medicaid does not cover the following psychological services:

- Testing for educational purposes
- Psychological evaluation, if provided to a child when an IEP is not subsequently established
- Review of educational records
- Classroom observation
- Scoring tests

Personal care paraprofessional services

Personal care paraprofessional services are medically necessary in-school services provided to clients whose health conditions cause them to be limited in performing activities of daily living. That is, these services are provided for clients with functional limitations.



Personal care services are not covered when provided by an immediate family member.

Services included

These activities of daily living services include:

- Dressing
- Eating
- Escorting on bus
- Exercising (ROM)
- Grooming
- Toileting
- Transferring
- Walking

Service requirements

- These services must be listed on the client's IEP.
- Approval must be given by the client's PASSPORT provider or primary care provider prior to billing for Medicaid covered services. For instructions on obtaining PASSPORT approval, see the *PASSPORT and Prior Authorization* chapter in this manual.

Services restricted

Medicaid does not cover the following services provided by a personal care paraprofessional:

- Skilled care services that require professional medical personnel
- Instruction, tutoring or guidance in academics
- Behavioral management

Please see *Appendix B: Personal Care Paraprofessional Services Documentation*, which includes the child profile and service delivery record. The child profile provides detailed examples of activities of daily living.

Special needs transportation

Special needs transportation includes transportation services for clients with special needs that are outside of traditional transportation services provided for clients without disabilities.

Services include

Special needs transportation services are covered when all of the following criteria are met:

- Transportation is provided to and/or from a Medicaid-covered service on the day the service was provided
- The Medicaid-covered service is included in the client's IEP
- The client's IEP includes specialized transportation service as a medical need.

The school district must maintain documentation of each service provided, which may take the form of a trip log.

Specialized transportation services are covered if one of the following conditions exists:

- A client requires transportation in a vehicle adapted to service the needs of students with disabilities, including a specially adapted school bus
- A client resides in an area that does not have school bus transportation (such as those in close proximity to a school).
- The school incurs the expense of the service regardless of the type of transportation rendered

Services included

Special needs transportation includes the following:

- Transportation from the client's place of residence to school (where the client receives health-related services covered by the Montana School-based Services program, provided by school), and/or return to the residence.
- Transportation from the school to a medical provider's office who has a contract with the school to provide health-related services covered by the Montana School-based Services program, and return to school.

Services restricted

Clients with special education needs who ride the regular school bus to school with other non-disabled children in most cases will not have a medical need for transportation services and will not have transportation listed in their IEP. In this case, the bus ride should not be billed to the Montana School-based Services program. The fact that clients may receive a medical service on a given day does not necessarily mean that special transportation also would be reimbursed for that day.

Audiology

Audiology assessments are performed by individuals possessing the state of Montana credentials for performing audiology services.

Services included

Covered audiology services include the following:

- Assessment to determine client's medical needs and/or to establish an IEP, as long as the assessment results in health-related services documented in the IEP.
- Services provided must be documented in the client's IEP.

Service requirements

Medicaid covers audiology services when the services to be provided during a school year are written into the child's IEP.



Medicaid does not cover special transportation services on a day that the client does not receive a Medicaid-covered service that is written into the IEP.

Services restricted

Medicaid does not cover the following audiology services:

- Testing for educational purposes
- Services provided during Child Find assessments

Authorization requirements summary

The following table is a summary of authorization requirements for school-based services that were described in each section above. For more information on how to obtain prior authorization and PASSPORT provider approval, see the *PASSPORT and Prior Authorization* chapter in this manual.

Authorization Requirements			
Service	Prior Authorization	PASSPORT Provider Approval	Written Physician Order/Referral
CSCT services*	No	No	No
Therapy services	No	Yes	No
Private duty nursing services	Yes	Yes	Yes
School psychologist and mental health services	No	No	No
Personal care paraprofessional services	No	Yes, if applicable (If the client is enrolled in PASSPORT, PASSPORT provider approval is required.)	Yes, if applicable (If the client is not enrolled in PASSPORT, the client's primary care provider must provide a written order/referral.)
Specialized transportation services	No	No	No
Audiology	No	No	No

* Outpatient mental health services provided by a private therapist or mental health professional must have prior approval when providing services concurrently with CSCT (concurrently means services provided during the same time or in combination to a youth that is receiving CSCT services).

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Children's Mental Health Services Plan (CMHSP)

The school-based services in this manual are not covered benefits of the Children's Mental Health Services Plan (CMHSP) administered by the Children's Mental Health Bureau. However, the mental health services in this chapter are covered benefits for Medicaid clients. For more information on the CMHSP program, see the *Mental Health* manual available on the Provider Information website (see *Key Contacts*).

Children's Health Insurance Plan (CHIP)

The school-based services in this manual are not covered benefits of the Children's Health Insurance Plan (CHIP). Additional information regarding CHIP benefits is available by contacting BlueCross BlueShield at 1-800-447-7828 ext. 8647.

PASSPORT and Prior Authorization

What Are PASSPORT, Team Care and Prior Authorization (ARM 37.86.5101 - 5120)

PASSPORT To Health, Team Care and prior authorization are three examples of the Department's efforts to ensure the appropriate use of Medicaid services. In most cases, providers need approval before services are provided to a particular client. PASSPORT approval and prior authorization are different, and some services may require both. A different code is issued for each type of approval and must be included on the claim (see the *Completing A Claim* chapter in this manual).

- **PASSPORT To Health Managed Care Program** is Montana Medicaid's Primary Care Case Management (PCCM) Program. Under PASSPORT, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider. Most Montana Medicaid clients must participate in PASSPORT with only a few exceptions. The PASSPORT Program saves the Medicaid Program approximately \$20 million each year. These savings allow improved benefits elsewhere in the Medicaid Program. For more information on PASSPORT To Health, see the *General Information For Providers* manual, *PASSPORT and Prior Authorization* chapter.
- **Team Care** is a utilization control and management program designed to educate clients on how to effectively use the Medicaid system. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. These clients must enroll in PASSPORT, select a PASSPORT primary care provider (PCP) and a single pharmacy, and call the Nurse First line prior to accessing Medicaid health services (except for emergency services). These clients receive extensive outreach and education from Nurse First nurses and are instructed on the proper use of the Montana Medicaid healthcare system. Team Care is a component of PASSPORT, and all PASSPORT rules and guidelines apply to these clients. For more information on the Team Care Program and Nurse First, see the *PASSPORT and Prior Authorization* chapter in the *General Information For Providers* manual or the *Team Care* page on the Provider Information website (see *Key Contacts*).
- **Prior authorization** refers to a list of services. If a service requires prior authorization, the requirement exists for all Medicaid clients. When prior authorization is granted, the provider is issued a PA number which must be on the claim. See *Prior Authorization* later in this chapter for instructions on how to obtain prior authorization for covered services.



Medicaid does not pay for services when prior authorization, PASSPORT, or Team Care Program requirements are not met.

In practice, providers will most often encounter clients who are enrolled in PASSPORT. Specific services may also require prior authorization regardless of whether the client is a PASSPORT enrollee. PASSPORT approval requirements are described below. In the few cases where an eligibility verification shows that a client is restricted to a certain provider or pharmacy, all providers must follow the restrictions on the eligibility documentation.

How to Identify Clients on PASSPORT

Client eligibility verification will indicate whether the client is enrolled in PASSPORT. The client's PASSPORT provider and phone number are also available on the eligibility verification, and the client may have full or basic coverage. Instructions for checking client eligibility are in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.

How to Obtain PASSPORT Approval

When providing a covered medical service that requires PASSPORT approval, check the child's eligibility information for the client's primary care provider. Contact the primary care provider and request approval. It is important to communicate results of the health-related services provided by school-based medical providers to the child's primary care provider to promote coordination and continuity of care. The PASSPORT approval number must be recorded on the claim (see the *Completing a Claim* chapter in this manual).

How to Obtain Extended PASSPORT Approval

You may want to consider getting an extended approval from PASSPORT providers in your area. The school can write to all the client's primary care providers at the beginning of each year. Ask providers to sign an extended approval, good for that entire year, for health-related services that will be provided to the child during the school year as indicated in the child's IEP. This extended approval is only good for health-related services requested for each individual child. A provider is not obligated to and may choose not to approve requested services. In signing this extended approval, the PASSPORT provider gives his or her PASSPORT provider number to use when submitting claims. The PASSPORT approval number must be recorded on the claim (see the *Completing a Claim* chapter in this manual). PASSPORT numbers may change within a given year. If a wrong PASSPORT number is used, the claim will deny. Providers should check clients' eligibility verification monthly. If a new PASSPORT provider is shown, contact that provider for a new PASSPORT number.

PASSPORT and Indian Health Services

Clients who are eligible for both Indian Health Services (IHS) and Medicaid may choose IHS or another provider as their PASSPORT provider. Clients who are eligible for IHS do not need a referral from their PASSPORT provider to obtain services from IHS. However, if IHS refers the client to a non-IHS provider, the PASSPORT provider must approve the referral.

Getting questions answered

The *Key Contacts* list (at the front of this manual) provides important phone numbers and addresses. Provider and Client Help Lines are available to answer almost any PASSPORT or general Medicaid question.

Prior Authorization

Some services require prior authorization (PA) before they are provided, such as private duty nursing services. When seeking PA, keep in mind the following:

- Always refer to the current Medicaid fee schedule to verify if PA is required for specific services.
- The following table (*PA Criteria for Specific Services*) lists services that require PA, who to contact, and specific documentation requirements.
- Have all required documentation included in the packet before submitting a request for PA (see the following *PA Criteria for Specific Services* table for documentation requirements).
- When PA is granted, providers will receive notification containing a PA number. This PA number must be included on the claim.

PA Criteria for Specific Services		
Service	PA Contact	Requirements
<ul style="list-style-type: none"> • Private Duty Nursing Services 	<p>Medicaid Utilization Review Department Mountain Pacific Quality Health Foundation P.O. Box 6488 Helena, MT 59604-6488</p> <p>Questions regarding this process can be answered by calling:</p> <p>Helena: (406) 443-4020 ext. 150</p> <p>Outside Helena: (800) 262-1545 ext. 150</p> <p>Fax: (406) 443-4585</p>	<p>The number of units approved for private duty nursing services is based on the time required to perform a skilled nursing task.</p> <ul style="list-style-type: none"> • A prior authorization request must be sent to the Medicaid Utilization Review Department's peer review organization accompanied by a physician or mid-level practitioner order/referral for private duty nursing. • Prior authorization must be requested at the time of initial submission of the nursing plan of care and any time the plan of care is amended. • Providers of private duty nursing services are responsible for requesting prior authorization and obtaining renewal of prior authorization. • Requests for prior authorization must be obtained for the regular school year (August/September through May/June). Services provided during the summer months must be prior authorized in addition to the services provided during the regular school year. Remember, schools are responsible for obtaining the physician orders and PASSPORT approval for new or amended requests for prior authorization. Prior authorization requests must be submitted to Mountain Pacific Quality Health Foundation <i>in advance</i> of providing the service. • Providers are required to send in prior authorization requests two weeks prior to the current prior authorization request end date for recipients receiving ongoing services. • Total number for units of service paid on claims must not exceed those authorized by the Medicaid Utilization Review Department. Payment will not be made for units of service in excess of those approved. • No retrospective prior authorization reviews will be allowed. • To request prior approval submit a completed <i>Request for Private Duty Nursing Services</i> form located in <i>Appendix A: Forms</i> of this manual and on the Provider Information website under <i>Forms</i>. Send completed requests to the contact shown in the second column.
<ul style="list-style-type: none"> • Outpatient mental health therapy provided outside or concurrently with CSCT 	<p>First Health Phone: (800) 770-3084 FAX: (800) 639-8982 Address: 4300 Cox Road Glen Allen, VA 23060</p>	<p>Client Name and ID MHC Provider Number Procedure code(s) Diagnosis (es)</p>

Other Programs

The Children's Mental Health Services Plan (CMHSP) and the Children's Health Insurance Plan (CHIP) do not cover school-based services. For more information on these programs, visit the Provider Information website (see *Key Contacts*).

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* later in this chapter). Medicare coverage is processed differently than other sources of coverage.

Identifying Other Sources of Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (see *Client Eligibility and Responsibilities* in the *General Information For Providers* manual). If a client has Medicare, the Medicare ID number is provided. If a client has other coverage (excluding Medicare), it will be shown under the "TPL" section. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' compensation insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

*These third party payers (and others) may **not** be listed on the client's eligibility verification.

Providers must use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as "third party liability" (TPL), but Medicare is not.

Medicare Part B crossover claims

Medicare Part B covers outpatient hospital care, physician care, and other services including those provided in a school setting. The Department has an agreement with Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]). Under this agreement, the carriers provide the Department with a magnetic tape of claims for clients who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically and must have their Medicare provider number on file with Medicaid.

In these situations, providers need not submit Medicare Part B crossover claims to Medicaid. Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see *Billing Procedures*).

When Medicare pays or denies a service

- When Medicare automatic crossover claims are paid or denied, they should automatically cross over to Medicaid for processing, so the provider does not need to submit the claim to Medicaid.
- When Medicare crossover claims are billed on paper and are paid or denied, the provider must submit the claim to Medicaid with the Medicare EOMB (and the explanation of denial codes).

When Medicaid does not respond to crossover claims

When Medicaid does not respond within 45 days of the provider receiving the Medicare EOMB, submit a claim with a copy of the Medicare EOMB to Medicaid for processing.

Submitting Medicare claims to Medicaid

When submitting a paper claim to Medicaid, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must include the Medicaid provider number and Medicaid client ID number. The Medicare EOMB and explanation of denial codes are required only if the claim was denied.

Remember to submit Medicare crossover claims to Medicaid only:
<ul style="list-style-type: none"> • When the referral to Medicaid statement is missing from the provider's EOMB. • When the provider does not hear from Medicaid within 45 days of receiving the Medicare EOMB. • When Medicare denies the claim.

To avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

All Part B Crossover claims submitted to Medicaid before Medicare's 45-day response time will be returned to the provider.

When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Billing Procedures* chapter in this manual.

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability (or TPL). In most cases, providers must bill other insurance carriers before billing Medicaid.

If a parent determines that billing their insurance would cause a financial hardship (e.g., decrease lifetime coverage or increase premiums), and refuses to let the school bill the insurance plan, the school cannot bill Medicaid for these services based on requirements of IDEA.

Providers are required to notify their clients that any funds the client receives from third party payers equal to what Medicaid paid (when the services were billed to Medicaid) must be turned over to the Department. Amounts in excess of what Medicaid paid must be returned to the provider. The following words printed on the client's statement will fulfill this requirement: "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

CSCT services

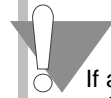
Procedure H0036 is a Medicaid-only code and other insurances do not recognize it as a valid procedure code. Providers of CSCT services must bill the appropriate CPT-4 code(s) to other payers, as those payers require (i.e. licensed staff may provide an individual therapy to a child in CSCT, bill CPT code that best describes service provided). When billing Medicaid after TPL, submit total charges/units for that date under the H0036 code and enter the amount paid by the other insurance on the claim. Do not bill CSCT services under any other code than H0036 to Medicaid.

Billing for Medicaid covered services when no IEP exists

In order to bill for Medicaid covered services that are not in the client's IEP, the school must meet all the following requirements:

- A fee schedule is established for health-related services (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

If the school bills private pay clients, then they must bill as follows for the services provided:



If a parent refuses to let the school bill their insurance plan, Medicaid cannot be billed either.

Client Insurance Status	Billing Process
Medicaid only*	Bill Medicaid
Private pay, no Medicaid	Bill family
Private insurance/Medicaid*	Bill private insurance before Medicaid
Private insurance, no Medicaid*	Bill private insurance

*Note: Under FERPA, schools must have written parental permission for release of information before billing Medicaid. For billing third party insurances, schools must have written permission for billing and written permission for release of information.

Billing for Medicaid covered services under an IEP

If a child is covered by both Medicaid and private insurance, and the services are provided under an IEP, providers must bill as follows:

Client Insurance Status	Billing Process
Medicaid only*	Bill Medicaid
Private pay, no Medicaid	Not required to bill family
Private insurance/Medicaid*	Bill private insurance before Medicaid
Private insurance, no Medicaid	Not required to bill private insurance

*Note: Under FERPA, schools must have written parental permission for release of information before billing Medicaid. For billing third party insurances, schools must have written permission for billing and written permission for release of information.

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first.

- When a Medicaid client is also covered by Indian Health Service (IHS) or the Montana Crime Victim's Compensation Fund, providers must bill Medicaid before IHS or Crime Victim's. These are not considered third party liability.
- When a client has Medicaid eligibility and Children's Mental Health Services Plan (CMHSP) eligibility for the same month, Medicaid must be billed before CMHSP.
- When a child is covered under BlueCross BlueShield or CHIP, providers may bill Medicaid first since these insurances do not cover services provided in a school setting.
- Medicaid must be billed before IDEA funds are used.

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to the ACS Third Party Liability Unit (see *Key Contacts*).

- If another insurance has been billed, and 90 days have passed with no response, include a note with the claim explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to Medicaid in order to avoid missing the timely filing deadline.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
 1. The third party carrier has been billed, and 30 days or more have passed since the date of service.
 2. The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.



If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

When the third party pays or denies a service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid in the “prior payments” form locator of the claim when submitting to Medicaid for processing.
- Allows the claim, and the allowed amount went toward client’s deductible, include the insurance EOB when billing Medicaid.
- Denies the claim, include a copy of the denial (including the denial reason codes) with the claim and submit to Medicaid. If a “blanket” denial is provided, the Department will accept and allow this denial for a period of no more than two years. The school must include a copy of this “blanket” denial with each submission for health-related services for each client. The “blanket” denial must be specific to the provider, client, and health-related services provided to the client. Blanket denials issued to schools without a client’s name will not be accepted.
- Denies a line on the claim, bill the denied lines together on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

When the third party does not respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Include a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company) with the claim.
- Include the date the claim was submitted to the insurance company.
- Send this information to the ACS Third Party Liability Unit (see *Key Contacts*).

Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically on a Professional claim or on a CMS-1500 paper claim form. CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- Twelve months from whichever is later:
 - the date of service
 - the date retroactive eligibility or disability is determined
- For claims involving Medicare or TPL, if the twelve month time limit has passed, providers must submit clean claims to Medicaid within:
 - **Medicare crossover claims:** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
 - **Claims involving other third party payers (excluding Medicare):** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12 month period.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 45 days, contact Provider Relations for claim status (see *Key Contacts*).

- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

When Providers Cannot Bill Medicaid Clients (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled client who was accepted as a Medicaid client by the provider, even if the claim was denied.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third-party payer does not respond.
- When a client fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments.
- When services are free to the client. Medicaid may not be billed for those services either.

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

There is no client cost sharing for school-based services.

Billing for Clients with Other Insurance

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client's health care, see the *Coordination of Benefits* chapter in this manual.

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the provider may:

- Accept the client as a Medicaid client from the current date.
- Accept the client as a Medicaid client from the date retroactive eligibility was effective.
- Require the client to continue as a private-pay client.

If a provider bills Medicaid and the claim is denied because the client is not eligible, the provider may bill the client directly.

When the provider accepts the client's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. Providers may need to contact the client's local office of public assistance (see the *General Information For Providers* manual, *Appendix B: Local Offices of Public Assistance*). When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the services before billing Medicaid for the services.

Service Fees

The Office of Management and Budget (OMB A-87) federal regulation specifies one government entity may not bill another government entity more than their cost. Schools should bill Medicaid their cost of providing a service, not the fee published by Medicaid for the service. The Medicaid fee schedule is to inform provider of the maximum fee Medicaid pays for each procedure.

Coding Tips

Effective January 1, 2004, the procedure codes listed in the following table will be the only valid procedures for schools to use for billing Medicaid. Although schools may continue to utilize the procedure codes published in the July 2003 fee schedule until that time, it is recommended that providers use only the following procedure codes.



Any codes billed by schools on or after January 1, 2004 that are not listed in the following table, will be denied.

School-Based Services Codes		
Service	CPT Code	Unit Measurement
Occupational Therapist		
Occupational therapy – individual therapeutic activities	97530	15 minute unit
Occupational therapy – group therapeutic procedures	97150	Per visit
Occupational therapy evaluation	97003	Per visit
Occupational therapy re-evaluation	97004	Per visit
Physical Therapist		
Physical therapy – individual therapeutic activities	97530	15 minute unit
Physical therapy – group therapeutic procedures	97150	Per visit
Physical therapy evaluation	97001	Per visit
Physical therapy re-evaluation	97002	Per visit
Speech Therapists		
Speech/hearing therapy – individual	92507	Per visit
Speech/hearing therapy – group	92508	Per visit
Speech/hearing evaluation	92506	Per visit
Private Duty Nursing		
Private duty nursing services provided in school	T1000	15 minute unit
School Psychologist/Mental Health Services		
Psychological therapy – individual	90804	Per 30 minute unit
Psychological therapy – group	90853	Per visit
Psychological evaluation and re-evaluation	96101	Per hour
CSCT Program		
CSCT services	H0036	15 minute unit
Personal Care Paraprofessionals		
Personal care services	T1019	15 minute unit
Special Needs Transportation		
Special needs transportation	T2003	Per one-way trip
Audiology		
Audiology evaluation	92557	Per visit
Tympanometry	92567	Per visit
Evoked otoacoustic emission; limited	92587	Per visit

Using modifiers

School-based services providers only use modifiers for coding when the service provided to a client is not typical. The modifiers are used in addition to the CPT codes. The following modifiers may be used in schools:

- Modifier “52” is billed with the procedure code when a service is reduced from what the customary service normally entails. For example, a service was not completed in its entirety as a result of extenuating circumstances or the well being of the individual was threatened.

- Modifier “22” is billed with the procedure code when a service is greater than the customary service normally entails. For example, this modifier may be used when a service is more extensive than usual or there was an increased risk to the individual. Slight extension of the procedure beyond the usual time does not validate the use of this modifier.
- Modifiers may also be required when providing two services in the same day that use the same code. See *Multiple Services on Same Date* for more information.

Multiple services on same date

When a provider bills Medicaid for two services that are provided on the same day that use the same CPT code and are billed under the same provider number, a modifier should be used to prevent the second service from being denied. The modifier “GO” is used for occupational therapy, and “GP” is used for physical therapy. For example, a school bills with one provider number for all services. The school provided occupational therapy for a client in the morning, and physical therapy for the same client in the afternoon of October 14, 2003. The claim would be billed like this:

24.	A DATE(S) OF SERVICE						B	C	D		E	F	G	H	I	J	K
	From To						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EP/SDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
1	10	14	03	10	14	03	03	0	97530	GO	1	\$ 22:00	1				
	10	14	03	10	14	03	03	0	97530	GP	1	\$ 22:00	1				

Time and units

- A provider may bill only time spent directly with a client. Time spent traveling to provide a service and paperwork associated with the direct service cannot be included in the time spent providing a service.
- Some CPT codes are designed to bill in units of 15 minutes (or other time increment) and others are “per visit”.
- If the service provided is using a “per visit” code, providers should use one unit of service per visit.
- When using codes that are based on a 15-minute time unit, providers should bill one unit of service for each 15-minute period of service provided. Units round up to the next unit after 8 minutes. Please use the following table as an average of the number of units of service to use. If the actual number of minutes providing a service falls between the range of minutes in the first two columns of the chart below, use the number of units in the third column.
- If a CSCT provider sees a client more than one time in a day, the entire time spent with the client that day should be totaled and billed once with the correct number of units as described in the following table.

Billing for Time in Units		
Minutes Greater Than	Minutes Less Than	Number of Units
8	23	1
24	38	2
39	53	3
54	68	4
69	83	5
84	98	6
99	113	7
114	128	8

Place of service

The only place of service code Montana Medicaid will accept is “03” (schools).

Billing for Specific Services

The following are instructions for billing for school-based services. For details on how to complete a CMS-1500 claim form, see the *Completing a Claim* chapter in this manual.

School-based providers can only bill services in the amount, scope, and duration listed in the IEP. Medicaid covered services provided under an Individual Education Plan (IEP) are exempt from the “free care” rule. That is, providers may bill Medicaid for a covered service provided to a client under an IEP even though they may be provided to non-Medicaid clients for free.

Assessment to initiate an IEP

When billing for assessments (evaluations), use the CPT code for the type of service being billed. When the unit measurement is “per visit”, only one unit may be billed for the assessment/evaluation. If the evaluation is completed over the course of several days, it is considered one evaluation. Bill the date span with 1 unit of service, not multiple units of service. For example, a speech/hearing evaluation completed over a three-day period would be billed like this:

24.	A DATE(S) OF SERVICE						B	C	D PROCEDURES, SERVICES, OR SUPPLIES		E	F	G	H	I	J	K
	From To						Place of Service	Type of Service	(Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPST Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER							
	09	23	03	09	26	03	03	0	92506		1	\$ 65.00	1				

A two-hour psychological assessment (evaluation) would be billed like this (the unit measurement for this code is “per hour”):

24.	A DATE(S) OF SERVICE						B	C	D PROCEDURES, SERVICES, OR SUPPLIES		E	F	G	H	I	J	K
	From To						Place of Service	Type of Service	(Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPST Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER							
	09	23	03	09	23	03	03	0	96100		1	\$ 90.00	2				

Medicaid covered services provided under and IEP are exempt from the “free care” rule.

Comprehensive School and Community Treatment (CSCT)

If a provider spent 30 minutes for individual counseling with a Medicaid client, it would be billed like this (the unit measurement for this code is 15 minutes):

24.	A						B	C	D			E	F	G	H	I	J	K
	DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	MM	DD	YY	MM	DD	YY												
	11	05	03	11	05	03	03	0		H0036			2		\$ 40:00	2		

The CSCT program must follow the free care rule. That is, if it is free for non-Medicaid children, then it is free for all children.

Therapy services

Services may be performed by a therapy assistant or therapy aide but must be billed to Medicaid under the supervising licensed therapist's (or school's) Medicaid provider number. Schools are responsible for assuring the proper supervision is provided for aides/assistants (see Covered Services Chapter). Remember to include the client's PASSPORT provider's PASSPORT approval number on the claim (field 17a of the CMS-1500 form). See the *Completing a Claim* chapter in this manual. Thirty minutes of individual physical therapy would be billed like this (the unit measurement for this code is "15 minute unit"):

24. A							B	C	D			E	F	G	H	I	J	K
DATE(S) OF SERVICE							Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE
From				To														
MM	DD	YY	MM	DD	YY													
12	02	03	12	02	03	03	0	97530				1	\$ 40:00	2				

Private duty nursing services

Both PASSPORT and prior authorization are required for these services, so remember to include the PASSPORT provider's PASSPORT number and the prior authorization number on the claim (see the *Completing a Claim* chapter in this manual). Private duty nursing services provided for 15 minutes would be billed like this:

24. A						B	C	D			E	F	G	H	I	J	K
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE
MM	DD	YY	MM	DD	YY			CPT/HCPCS MODIFIER									
09	02	03	09	02	03	03	0	T1000			1	\$ 5:00	1				

School psychologists and mental health services

A psychological therapy session of 30 minutes would be billed like this (the unit measurement for this code is "per 30 minute unit"):

24. A						B	C	D			E	F	G	H	I	J	K
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE
From	MM	DD	YY	To	MM												
	MM	DD	YY	MM	DD	YY											
	09	02	03	09	02	03	03	0	90804			1	\$ 50:00	1			

Personal care paraprofessional services

Remember to include the client's PASSPORT provider number on the claim (see the *Completing a Claim* chapter in this manual). Personal care services provided to a client for 2 hours during a day would be billed like this (the unit measurement for this code is per 15 minute unit):

24.		A						B	C	D			E	F	G	H	I	J	K
		DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE
MM	DD	YY	MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER									
09	02	03	09	02	03	03	0		T1019				1	\$ 24:00	8				



The CSCT program must follow the *free care rule*.

Special needs transportation

School districts must maintain documentation of each service provided, which may take the form of a trip log. Schools must bill only for services that were provided. Special transportation should be billed on a per one-way trip basis. For example, if a client was transported from his or her residence to school and received Medicaid covered health-related services that day, and then transported back to his or her residence, it would be billed like this:

24.	A DATE(S) OF SERVICE						B	C	D		E	F	G	H	I	J	K
	From To						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPST Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER							
	09	02	03	09	02	03	03	0	T2003		1	\$ 20.00	2				

Audiology

An audiology assessment would be billed like this (the unit measurement for this code is “per visit”):

24.	A DATE(S) OF SERVICE						B	C	D		E	F	G	H	I	J	K
	From To						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPST Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER							
	09	02	04	09	02	04	03	0	92557		1	\$ 35.00	1				

Submitting Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- **ACS field software WINASAP 2003.** ACS makes available this *free* software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- **ACS clearinghouse.** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFICS certifies the 837 HIPAA transactions at no cost to the provider. EDIFICS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).
- **Clearinghouse.** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's

clearinghouse also needs to have their 837 transactions certified through EDIFICS before submitting claims to the ACS clearinghouse. EDIFICS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing Electronically with Paper Attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

<u>9999999</u>	-	<u>888888888</u>	-	<u>11182003</u>
Medicaid		Client ID		Date of
Provider ID		Number		Service
				(mmdyyy)

The supporting documentation must be submitted with a paperwork attachment coversheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Submitting Paper Claims

For instructions on completing a paper claim, see the *Completing a Claim* chapter in this manual. Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, client eligibility, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A*. Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct Medicaid provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, hand-written, or computer generated.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client, verify client eligibility by using one of the methods described in the <i>Client Eligibility and Responsibilities</i> chapter of the <i>General Information For Providers</i> manual. Medicaid eligibility may change monthly.
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim when such approval is required. PASSPORT approval is different from prior authorization. See the <i>PASSPORT and Prior Authorization</i> chapter in this manual.
Prior authorization number is missing	<ul style="list-style-type: none"> Prior authorization (PA) is required for certain services, and the PA number must be on the claim. Prior authorization is different from PASSPORT authorization. See the <i>PASSPORT and Prior Authorization</i> chapter in this manual.
Prior authorization does not match current information	<ul style="list-style-type: none"> Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.

Common Billing Errors (continued)	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Duplicate claim	<ul style="list-style-type: none"> • Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim (see <i>Remittance Advices and Adjustments</i> in this manual).
TPL on file and no credit amount on claim	<ul style="list-style-type: none"> • If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See <i>Coordination of Benefits</i> in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see <i>Key Contacts</i>) before submitting a claim.
Claim past 12-month filing limit	<ul style="list-style-type: none"> • The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in <i>Key Contacts</i>.
Missing Medicare EOMB	All denied Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached, and be billed to Medicaid on paper.
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number terminated	<ul style="list-style-type: none"> • Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Procedure is not allowed for provider type	<ul style="list-style-type: none"> • Provider is not allowed to perform the service. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

The Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP) do not cover school-based services. For more information on these programs, visit the Provider Information website (see *Key Contacts*). Additional information regarding CHIP benefits is available by contacting BlueCross BlueShield at 1-800-447-7828 ext. 8647

Completing a Claim Form

The services described in this manual are billed either electronically on a Professional claim or on a CMS-1500 paper claim form. Claims submitted with all of the necessary information are referred to as “clean” and are usually paid in a timely manner (see the *Billing Procedures* chapter in this manual).

When completing a claim, remember the following:

- Required fields are indicated by “*”.
- Fields that are required if the information is applicable to the situation or client are indicated by “**”.
- Field 24h, *EPSDT/family planning*, is used as an indicator to specify additional details for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Indicators		
Code	Client/Service	Purpose
1	EPSDT	This indicator is used when the client is under age 21
2	Family planning	This indicator is used when providing family planning services.
3	EPSDT and family planning	This indicator is used when the client is under age 21 and is receiving family planning services
4	Pregnancy (any service provided to a pregnant woman)	This indicator is used when providing services to pregnant women
6	Nursing facility client	This indicator is used when providing services to nursing facility residents

- Unless otherwise stated, all paper claims must be mailed to the following address:

Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

Sample Claim

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a**	Insured's ID number	Leave this field blank for Medicaid only claims. For clients with Medicare, enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number (UPIN).
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Place of service</i> in the <i>Billing Procedures</i> chapter).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid allows up to three modifiers per procedure code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter \$0.00. Do not report any client copay or Medicaid payment amounts on this form. The Medicare payment amount will be determined from the EOMB attached to the claim.
30	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Sample Claim

APPROVED OMB-0938-0008																													
For Medicaid use. Do not write in this area.																													
HEALTH INSURANCE CLAIM FORM																													
PICA <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Chuckie L.					3. PATIENT'S BIRTH DATE MM DD YY 04 28 92 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																			
CITY Anytown					STATE MT					CITY					STATE														
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 555-5555					ZIP CODE					TELEPHONE (INCLUDE AREA CODE)														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____					b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE 999999999					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																			
14. DATE OF CURRENT: MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Doug Ross, MD					17a. I.D. NUMBER OF REFERRING PHYSICIAN 9989999					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 313.31					23. PRIOR AUTHORIZATION NUMBER																								
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE																													
1 09 09 03 09 09 03 03 0 92507 1 \$ 30.00 1																													
2 09 16 03 09 16 03 03 0 92507 1 \$ 30.00 1																													
3 09 22 03 09 22 03 03 0 92508 1 \$ 12.50 1																													
4																													
5																													
6																													
25. FEDERAL TAX I.D. NUMBER 99-9999999					26. PATIENT'S ACCOUNT NO. 99999					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 72.50					29. AMOUNT PAID \$					30. BALANCE DUE \$ 72.50				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>Sally Jones</i> 09/30/03 SIGNED _____ DATE _____					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) Public School 123 Education Drive Anytown, MT 59999					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Public School P.O. Box 999 Anytown, MT 59999 PIN# 0000099999 GRP# (406) 555-5555																			

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

CMS-1500 Agreement

Your signature on the CMS-1500 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services provided were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101.41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double check each claim to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

Common Claim Errors	
Claim Error	Prevention
Required field is blank	Check the claim instructions earlier in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required field (field 10d); verify that the client's Medicaid ID number is listed as it appears on the client's ID card.
Client name missing	This is a required field (field 2); check that it is correct.
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct Medicaid provider number is on the claim.
Referring or PASSPORT provider name and ID number missing	When a provider refers a client to another provider, include the referring provider's name and ID number or PASSPORT number (see <i>PASSPORT and Prior Authorization</i> in this manual).
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in field 23 (see <i>PASSPORT and Prior Authorization</i> in this manual).
Not enough information regarding other coverage	Fields 1a and 11d are required fields when a client has other coverage (refer to the examples earlier in this chapter).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Medicare EOMB not attached	When Medicare is involved in payment on a claim, the Medicare EOMB must be attached to the claim or it will be denied.

Other Programs

This chapter also applies to claims forms completed for MHSP services and CHIP eyeglass services.

Remittance Advices and Adjustments

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic RA

Providers may receive the RA electronically as an ANSI ASC X12N 835 transaction, or through the Internet on the Montana Eligibility and Payment System (MEPS). For more information on X12N 835 transactions, see the Companion Guides available on the ACS EDI Gateway website and the Implementation Guides on the Washington Publishing Company website (see *Key Contacts*).

MEPS is available through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form*; see *Payment and the RA* within this chapter). After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the “SOR Download” page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks. For more information on MEPS, see *Payment and the RA* in this chapter.

Paper RA

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.



Electronic RAs are available for only six weeks on MEPS.



If a claim was denied, please read the description of the EOB before taking any action on the claim.



The pending claims section of the RA is informational only. Please do not take any action on claims displayed here.

Sections of the Paper RA

Section	Description
RA notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid claims	This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see <i>Adjustments</i> later in this chapter).
Denied claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See <i>The Most Common Billing Errors and How to Avoid Them</i> in the <i>Billing Procedures</i> chapter.
Pending claims	<p>All claims that have not reached final disposition will appear in this area of the paper RA (pending claims are not available on X12N 835 transactions). The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.</p> <p>Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.</p>
Credit balance claims	Credit balance claims are shown here until the credit has been satisfied.
Gross adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and remark code description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES HELENA, MT 59604										① PUBLIC SCHOOL 2100 NORTH MAIN STREET WESTERN CITY MT 59988
MEDICAID REMITTANCE ADVICE										
②	③			④	⑤					⑥
PROVIDER# 0001234567	REMIT ADVICE #123456			WARRANT # 654321	DATE:10/15/03	PAGE 2				
⑦	⑧	⑩	⑪	⑫	⑬	⑭	⑮	⑯		
RECIP ID	NAME	SERVICE DATES FROM TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO- PAY	REASON/ REMARK CODES		
PAID CLAIMS - MISCELLANEOUS CLAIMS										
123456789	DOE, JOHN EDWARD	100103 100103	1	97530	23.74	23.74	N			
⑨	ICN 00327411250000700	***LESS MEDICARE PAID*****				21.25				
		CLAIM TOTAL **			23.74	2.49		⑰		
DENIED CLAIMS - MISCELLANEOUS CLAIMS										
123456789	DOE, JOHN EDWARD	100203 100203	1	92507	53.54	0.00	N			
	ICN 00327511250000800	100203 100203	1	92508	21.76	0.00		⑰	31MA61	
		CLAIM TOTAL **			75.30					
PENDING CLAIMS - MISCELLANEOUS CLAIMS										
123456789	DOE, JOHN EDWARD	100303 100203	1	90804	51.67	0.00		⑰	N 133	
	ICN 00327611250000900	100203 100203	1	92507	53.54	0.00	N		133	
		CLAIM TOTAL **			105.21					
*****THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE*****										
31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.									
133	THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.									
MA61	DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.									

Key Fields on the Remittance Advice

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider by Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	<p>Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information:</p> <p><u>0</u> <u>00111</u> <u>11</u> <u>123</u> <u>000123</u> A B C D E</p> <p>A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or point-of-sale (POS) pharmacy claim) B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)</p>
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns
11. Unit of service	The units of service rendered under this procedure or NDC code.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. Reason and remark codes	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Credit balances

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

1. By “working off” the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting Provider Relations (see *Credit balances* #2 above) to complete a gross adjustment.

Rebilling Medicaid

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Completing a Claim* chapters.

When to rebill Medicaid

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Reason and/or Remark code, make the appropriate corrections, and resubmit the claim (not an adjustment).



The credit balance section is informational only. Do not post from credit balance statements.



Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in *Billing Procedures* chapter).



Rebill denied claims only after appropriate corrections have been made.

- **Line Denied.** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Do not use an adjustment form.
- **Claim Returned.** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to rebill

- Check any Reason and/or Remark code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to cross out or omit all lines that have already been paid. The claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or include insurance denial information, and submit to Medicaid.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see the *Billing Procedures* chapter, *Claim Inquiries*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

Adjustments
can only be
made to paid
claims.



How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in Appendix A. The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.

MONTANA MEDICAID/MHSP/CHIP INDIVIDUAL ADJUSTMENT REQUEST			
INSTRUCTIONS: This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the <u>paid</u> claim from your statement. Complete <u>ONLY</u> the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the <i>Remittance Advices and Adjustments</i> chapter in your program manual or the <i>General Information For Providers II</i> manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).			
A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION			
1. PROVIDER NAME & ADDRESS	3. INTERNAL CONTROL NUMBER (ICN)		
Public School	00327211250000600		
Name	4. PROVIDER NUMBER		
2100 North Main Street	1234567		
Street or P.O. Box	5. CLIENT ID NUMBER		
Western City, MT 59988	123456789		
City State Zip	6. DATE OF PAYMENT		
	10/15/02		
2. CLIENT NAME	7. AMOUNT OF PAYMENTS		
Jane Doe	11.49		
B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED			
	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	1
2. Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	10/01/02	10/02/02
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			
SIGNATURE: <u>John R. Smith, M.D.</u> DATE: <u>10/31/03</u>			
When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).			
MAIL TO: Provider Relations ACS P.O. Box 8000 Helena, MT 59604			

Sample Adjustment Request

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from Appendix A. You may also order forms from Provider Relations or download them from the Provider Information website (see *Key Contacts*). Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
 - Enter the date of service or the line number in the *Date of Service or Line Number* column.
 - Enter the information from the claim that was incorrect in the *Information on Statement* column.
 - Enter the correct information in the column labeled *Corrected Information*.

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Recipient name	The client's name is here.
3.* Internal control number (ICN)	There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Recipient Medicaid number	Client's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice field #5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice field #17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/ NDC/ Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (Nursing facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
 - If the original claim was billed electronically, a copy of the RA will suffice.
 - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit. If the result is a credit balance, it can be worked off or the provider can pay off the balance by check (see *Credit balances* earlier in this chapter).
- Any questions regarding claims or adjustments must be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a “4” (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and The RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

With EFT, the Department deposits the funds directly to the provider’s bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A). One form must be completed for each provider number. See the following table, *Required Forms for EFT and/or Electronic RA*.



Electronic RAs are available for only six weeks on MEPS.



Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. See *Direct Deposit Arrangements* under *Key Contacts* for questions or changes regarding EFT.

Required Forms For EFT and/or Electronic RA All three forms are required for a provider to receive weekly payment			
Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	<ul style="list-style-type: none"> • Provider Information website • Provider Relations (see <i>Key Contacts</i>) 	Provider Relations (see <i>Key Contacts</i>)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	<ul style="list-style-type: none"> • Provider Information website (see <i>Key Contacts</i>) • Provider's bank 	Provider Relations (see <i>Key Contacts</i>)
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	<ul style="list-style-type: none"> • Provider Information website • Virtual Human Services Pavilion • Direct Deposit Arrangements (see <i>Key Contacts</i>) 	DPHHS address on the form

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter in order to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims. The payment methods described do not apply to services provided under the Children's Health Insurance Program (CHIP).

Certification of State Match

A state certification of match process allows the state to leverage public education dollars to draw down federal funds. The state of Montana has implemented a state certification of match process for purposes of drawing down Federal Medical Assistance Percentage (FMAP) for the school based fee-for-service program. The FMAP rate fluctuates each year and will be reflected in reimbursements to schools. DPHHS is working in conjunction with the Office of Public Instruction (OPI) in the certification of match process for Medicaid covered school-based health-related services. This process includes all direct services billed to Medicaid under the School-based Health Services program including CSCT services that are written into an IEP.

CSCT services included in IEP

If CSCT services are included on a child's IEP, then the school district/cooperative does not need to do anything else to certify match for federal funds to be drawn down. Health services that are part of the Medicaid School-based Health Services program and are included on the IEP are covered by OPI's certification of match procedure that is based on the trustees' financial summary report utilizing special education expenditures that are documented and maintained at the state level. This greatly simplifies the process for matching federal funds.

CSCT services not included in IEP

The CSCT program, like all other services that are included in the Medicaid School-based Health Services program require certification of the use of local and state funds to match the state portion of the Medicaid funds. Because services are provided to children who do not have an IEP there is a requirement that schools who administer the CSCT program verify that the district has sufficient state and local funds to support the CSCT program in order to draw down the federal funds for children that are receiving CSCT services that are not included on an IEP. This match is required on an annual basis to DPHHS.

This match must come from non-federal sources. State special education funds and federal funds cannot be used for purposes of this match. The following formula will assist district in calculating the district's match obligation:

Medicaid payment for CSCT Services / Current FMAP Rate X Current State Match Rate = Local District Match

The annual certification of match will be due at the end of December of each year. CSCT services are reimbursed to schools by federal Medicaid funds. This means that a school is required to certify non-federal expenditures to cover the district costs associated with CSCT services. Insufficient match will result in a payback.

Appendix C: CSCT has a Sample Certification of Match Statement, which shows a sample of the document that the school district/cooperative will receive annually for DPHHS that shows the amount of money that has been expended on CSCT services and the required state and local funds that must be certified for the federal match. The school district/cooperative must certify, by signing the document, that sufficient state and local expenditures (the amount listed in item 3 of the Sample Certification of Match Statement) have been used to support this program. The Certification of Match Statement must be returned to DPHHS. If the school district/cooperative have provided CSCT services to clients as part of the IEP, please contact DPHHS to obtain a breakdown by client to calculate reimbursement for services that were not included on IEPs for matching purposes.

For audit purposes, the district must maintain documentation that validates that local and state dollars were spent. This documentation does not necessarily have to show the exact funds that are certified but must demonstrate that sufficient state and local funds were spent (and that these funds were not used as certification of federal match elsewhere). The documentation that validates non-federal funds used to certify to match must be retained for seven years.

Requirements for matching expenditures

- The matching funds can include both direct and indirect expenses.
- The matching funds can include expenses that were paid by state and local dollars.

Restrictions for matching expenditures

- Matching funds for this program cannot include federal dollars like:
 - IDEA funds
 - Medicaid reimbursement

How to document expenditures used to certify match

Each school district or cooperative can document these funds in a variety of ways. The key is to be able to identify that sufficient state and local funds were available to use for federal match. Districts can:

- Develop a program code within the accounting system to capture expenditures for the CSCT program costs.
- Develop work papers that verify which dollars of local and state expenditures were used for matching.

Payment for School-Based Services

Federal regulations specify that one government entity may not bill another government entity more than their cost (OMB A-87). The following describes payment methods for various services that can be provided in the school setting. Payment for these services is limited to the lower of the calculated fee or the billed amount.

Speech, occupational and physical therapy services

Speech and language therapy services, occupational therapy services and physical therapy services are paid by the RBRVS method of reimbursement. RBRVS stands for Resource Based Relative Value Scale. These services are paid 90% of the RBRVS office fee paid to physicians for the same service. As noted above, only the federal portion will be paid. For more detail on the RBRVS system, see the *How Payment Is Calculated* chapter of the *Physician Related Services* provider manual, which is available on the Provider Information website (see *Key Contacts*).

The following illustrates how RBRVS payments are calculated for therapy services. Examples are for illustration only. The numerical examples are from July 2003 and may not apply at other times.

Each RBRVS fee is the product of a relative value times a conversion factor, multiplied by 90%. For example, the fee for a physical therapy evaluation (CPT code 97001) is:

1.825 relative weight x conversion factor of \$31.18 x 90% = \$51.21 per visit

The federal portion of this fee is $\$51.21 \times .7591 = \38.87 per visit

The fee for a therapeutic activities (OT) code (CPT code 97530) is:
 $.704$ relative weight \times conversion factor of $\$31.18 \times 90\% = \19.75 per 15 minute unit

The federal portion of this fee is $\$19.75 \times .7591 = \14.99 per 15 minute unit

The Department publishes relative weights and the current conversion factor. The conversion factor is determined by the Department, and set at a level intended to achieve legislatively set budget targets.

Private duty nursing

The only code available for this service is T1000. Payment for this code is based on the Medicaid fee schedule, and is calculated as follows:

Fee \times number of 15 minute units = payment

For 30 minutes of service:

$\$5.25 \times 2 = \10.50 for two 15 minute units

The federal portion of this payment is $\$10.50 \times .7591 = \7.97 for two 15 minute units

School psychologist

Both codes available for billing school psychologist services are paid by the RBRVS method.

The following illustrates how RBRVS payments are calculated. Examples are for illustration only. The numerical examples are from July 2003 and may not apply at other times.

Each RBRVS fee is the product of a relative value times a conversion factor, multiplied by 90%. For example, the fee for psychological therapy (CPT code 90804) is:

1.618 relative weight \times conversion factor of $\$31.18 \times 90\% = \49.95 per 30 minute unit

The federal portion of this payment is $\$49.95 \times .7591 = \37.91

The Department publishes relative weights and the current conversion factor. The conversion factor is determined by the Department, and set at a level intended to achieve legislatively set budget targets.

Personal care paraprofessionals

The only code available for this service is T1019. Payment for this code is based on the Medicaid fee schedule, and is calculated as follows:

Fee x number of 15 minute units x 90% = payment

$\$3.45 \times 2 \times 90\% = \$ 6.21$ for two 15 minute units

The federal portion of this payment is $\$6.21 \times .7591 = \$ 5.58$

CSCT Program

The only code available for this service is H0036. Payment for this code is based on the Medicaid fee schedule, and is calculated as follows:

Fee x number of 15 minute units x 90% = payment

$\$24.46 \times 2 \times 90\% = \$ 44.02$ for two 15 minute units

The federal portion of this payment is $\$ 44.02 \times .7591 = \33.41

All payments for CSCT services are made to the school district/cooperative. Schools may not assign payment from Medicaid directly to the mental health center provider. The purpose of this policy is to:

- Ensure that districts are fully aware of the amount of Federal Medicaid funds generated by their CSCT providers, allowing districts to determine their obligation for match.
- Control variables are in place to account for districts revenue and expenditures.

How payment is calculated on TPL claims

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as Third Party Liability or TPL. In these cases, the other insurance is the primary payer (as described in the Coordination of Benefits chapter of this manual), and Medicaid makes a payment as the secondary payer. Medicaid will make a payment only when the TPL payment is less than the Medicaid allowed amount.

How payment is calculated on Medicare crossover claims

When a client has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the co-insurance and deductible amounts for these dually eligible individuals. See the *How Payment is Calculated* chapter in the *Physician Related Services* manual for examples on how payment is calculated on Medicare crossover claims.

Appendix A: Forms

- *Montana Medicaid/MHSP/CHIP Individual Adjustment Request*
- *Montana Medicaid Claim Inquiry Form*
- *Audit Preparation Checklist*
- *Request for Private Duty Nursing Services*
- *Paperwork Attachment Cover Sheet*

**MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST**

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete **ONLY** the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS _____ Name _____ Street or P.O. Box _____ City State Zip	3. INTERNAL CONTROL NUMBER (ICN) _____ 4. PROVIDER NUMBER _____ 5. CLIENT ID NUMBER _____ 6. DATE OF PAYMENT _____ 7. AMOUNT OF PAYMENT \$ _____
2. CLIENT NAME _____	

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC) 			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

**MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604**

Montana Medicaid Claim Inquiry Form

Provider Name _____
 Contact Person _____
 Address _____
 Date _____
 Phone Number _____
 Fax Number _____



For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____ _____ _____ _____ _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____ _____ _____ _____ _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____ _____ _____ _____ _____

Mail to:

Provider Relations
 P.O. Box 8000
 Helena, MT 59604

Fax to: (406) 442-4402

Audit Preparation Checklist

For the Montana Medicaid School-Based Services Program, school districts and cooperatives retain responsibility for ensuring that program requirements are met. Schools may not be in compliance if any statement below is checked “No.”

Service Provider Qualifications			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Do all individual service providers meet the established provider qualifications for the Montana Medicaid School-Based Services Program for their discipline?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is there documentation that the service providers are credentialed?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Do you verify and maintain contractor provider credentials?
Services Indicated on IEP			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is the service that is being billed included in the IEP?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Does the IEP document services that are necessary and being provided as part of the school-based health services program?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Does a team that includes school personnel and qualified providers of health services develop all IEPs?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Does the IEP confirm that services are authorized as medically necessary as certified by a practitioner of the healing arts within their scope of practice?
Service Documentation			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is the billing documentation accurate for services performed (including student name, date of service, duration of service, type of service and notes that show progress toward student goals)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Are all service documentation records regularly maintained by the service provider on the day that services are provided?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Are all service documentation records available at a central district location during an audit?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is evaluation reimbursement only requested for health related evaluations that are completed to determine if a student requires special education services?
Special Needs Transportation Services			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Are special transportation services listed on the IEP?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Did the student receive Medicaid reimbursable services on the same day that transportation reimbursement is being requested?
Billing Information			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is third party insurance pursued for students with dual insurance coverage?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Do you have documentation retained for a period of six years and three months from the date of service?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Do you have a process in place to maintain contracted providers' service documentation?

Private Duty Nursing Services School Based Services



Requests for authorizations should be sent to:

Mountain Pacific Quality Health, 3404 Cooney Drive, Helena MT 59602
phone: (406) 443-4020 or (800) 262-1545 ext. 5850 fax: (406) 443-4585 or (800) 497-8235

Request for Authorization

Client Name: Last, First, MI			Medicaid ID#:	
Street Address:		City:		State: Zip:
DOB:	Age:	Sex: M F		
Will any member of the client's family, or household, who is a licensed RN or LPN, be providing nursing services? <input type="checkbox"/> No <input type="checkbox"/> Yes				
School/Provider Name:			Provider #:	
School Contact:		Phone #:	Fax #:	
School Nurse/Caregiver's name:			Title/Position:	
Physician's name:			Phone #:	
Principal diagnosis:				

Request for services to be provided in the school

Number of skilled service hours requested per day:						Total
Mon-	Tues-	Wed-	Thur-	Fri-		
Date school year starts:		Date school year ends:			Summer school dates:	
Skilled services and treatments to be provided (frequency, estimated time/service):						
<input type="checkbox"/> Medication administration: <input type="checkbox"/> Oral <input type="checkbox"/> G-Tube <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> SQ						
List medications and frequency:						
Name of person who actually administers medications to students:						Position:
<input type="checkbox"/> Trach suctioning/care						
<input type="checkbox"/> Vent care						
<input type="checkbox"/> Sterile dressing changes						
<input type="checkbox"/> Tube Feedings: <input type="checkbox"/> Continuous pump <input type="checkbox"/> Bolus						
<input type="checkbox"/> Other:						
If meds or treatments are ordered PRN, accurate records of date, time and duration of the treatments must be submitted at the end of the date span.						

☐ Signed Doctor's orders are attached

Signature of person submitting request

Date

All private duty nursing services must be prior authorized. Requests for services provided in the school may be authorized for the duration of the regular school year. Services provided during the summer months are additional services that require separate prior authorization. Additional requests may be submitted any time the condition of the child changes, resulting in a change to the amount of skilled nursing services required.

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of service: _____

Medicaid provider number: _____

Medicaid client ID number: _____

Type of attachment: _____

Instructions:

This form is used as a cover sheet for attachments to electronic claims sent to Montana Medicaid. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's Medicaid ID number, the client's Medicaid ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from our website www.mtmedicaid.org. If you have questions about which paper attachments are necessary for a claim to process, please call Provider Relations at (406) 442-1837 or (800) 624-3958.

Appendix B: Personal Care Paraprofessional Services Documentation

- *Child Profile*
- *Child Profile Form*
- *Task/Hour Guide Instructions*
- *Task/Hour Guide*

Personal Care Paraprofessional Services Provided in Schools – Child Profile

Purpose

The Child Profile is intended to:

- To provide an instrument for collecting and documenting essential information needed to establish the Medicaid child's functional limitations and ability to perform activities of daily living.
- To document information on service planning issues for personal care services.
- To provide a worksheet for determining the daily units per week needed by the child.

Procedure

The Profile must be completed by the Individualized Education Plan (IEP) team at the initial meeting for services, at the annual review, and whenever a significant change in the child's condition occurs causing the service need to change.

Instructions

1. Child Name: Enter the child's full name.
2. Child ID: Enter child's Medicaid ID number.
3. DOB: Child's date of birth.
4. Date Span: The time period the child will receive personal care services, up to one year.
5. Level of Impairment: Rate the child's impairment level according to the following scale for each task listed:
 - 0 = Independent: No functional impairment. The child is able to conduct the activities without difficulty and has no need for assistance. Need is met with adaptive equipment or service animal.
 - 1 = Standby/Cuing: Mild functional impairment. The child is able to conduct the activity but does require standby assist or cuing.
 - 2 = Limited Assist: Moderate functional impairment. The child is able to conduct the activity with moderate difficulty and requires minimal assistance.
 - 3 = Extensive Assist: Severe functional impairment. The child has considerable difficulty completing the activity and requires extensive assistance.
 - 4 = Total Dependence: Total functional impairment. The child is completely unable to carry out any part of the activity.

An IEP team member must decide which of the five impairment levels best describes the child reviewed. An impairment in this context is a functional limitation, i.e., a limitation in the ability to carry out an activity or function. A client is considered to have an impairment with respect to a particular activity if he/she is limited, either physically or mentally, in his/her ability to carry out that activity.

The “0” and “4” rating is absolute in the sense that they indicate no functional impairment or total dependency. For example, if a child can perform any of the dressing tasks for themselves, a “4” is not appropriate. If he/she can perform the dressing task without difficulty, a “0” is appropriate.

If a child is able to conduct an activity only with difficulty, and the difficulty is such that the child frequently cannot complete some part of the activity, then the child is impaired, even if the child at other times can complete the entire activity. In addition, if the degree of difficulty is such that the child should have at least minimal assistance with that activity, then the child is impaired, even if the child can (with difficulty) conduct the activity without assistance. If the child can complete the activity but needs cuing to do so, or, because of safety considerations needs someone there while completing the task, they would require standby assistance. If the difficulty with an activity does not affect the child's conduct of the activity or does not cause any problems for the child, the child is not impaired.

Enter a level for each task

The Personal Care Paraprofessional Services Profile is designed to rate a child's capacity for self-care. Determine the level for each task according to the capacity for self-care and not according to the child's access to a resource to assist with the task. In rating each item, use the child's response, your own observations of activity, and any knowledge provided about the child from other sources. To determine the severity of the child's impairment, consider the following factors:

1. Child Perception of the Impairment: Does the child view the impairment as a major or minor problem?
2. Congruence: Is the child's response to a particular question consistent with the child's response to other questions and, also, consistent with what you have observed?
3. Child History: Probe for an understanding of the child's history as it relates to the current situation and of the child's attitude about the severity of the impairment. How has the impairment changed the child's lifestyle?
4. Adaptation: If the child has adapted his physical environment or clothing to the extent that he is able to function without assistance, the degree of impairment will be lessened, but the child will still have an impairment. This includes the use of adaptive equipment.

Use the following examples for each item to help you differentiate between scores of “2” or “3”.

ADL	2 = Limited Assist	3 = Extensive
Dressing	Child needs <i>occasional</i> help with zippers, buttons, or putting on shoes and socks. Child may need help laying out and selecting clothes.	Child needs help with zippers, buttons, or shoes and socks. Child needs help getting into garments, including putting arms in sleeves, legs in pants, or pulling up pants. Child may dress totally inappropriately without help or would not finish dressing without physical assistance.
Grooming	Child may set out supplies. Child may accomplish tasks an adaptive device for assistance.	Child needs to have help with shaving <i>or</i> shampooing, etc., because of inability to see well, to reach, or to successfully use equipment. Child needs someone to put lotion on body or to comb or brush hair.
Toileting	Child has instances of urinary incontinence, and needs help because of this from time to time. Fecal incontinence does not occur unless child has a specific illness episode. Child may have catheter or colostomy bag, and occasionally needs assistance with management.	Child often is unable to get to the bathroom on time to urinate. Child has occasional episodes of fecal incontinence. Child may wear diapers to manage the problem and needs some assistance with them. Child usually needs assistance with catheter or colostomy bag.
Transferring	Child usually can get out of bed or chair with minimal assistance.	Child needs hands-on assistance when rising to a standing position or moving into a wheelchair to prevent losing balance or falling. Child is able to help with the transfer by holding on, pivoting, and/or supporting himself.
Ambulation	Child walks alone without assistance for only short distances. Child can walk with minimal difficulty using an assistive device or by holding onto walls or furniture.	Child has considerable difficulty walking even with an assistive device. Child can walk only with assistance from another person. Child never walks alone outdoors without assistance. Child may use a wheelchair periodically.
Eating	Child may need occasional physical help. Child eats with adaptive devices but requires help with their positioning	Child usually needs extensive hands-on assistance with eating. Child may hold eating utensils but needs continuous assistance during meals. Child would not complete meal without continual help. Spoon-feeding of most foods is required, but child can eat some finger foods.
Exercise	Child may need occasional assistance in completing exercise routine. Child may need occasional support or guidance.	Child needs some assistance in completing exercise routine. Child needs support or guidance.
Bus Escort	Child requires minimal assistance on bus en route to or from school. Child does not have family or caregiver to assist. Child receives a medical service at school on this date.	Child requires assistance on bus en route to or from school. Child does not have family or caregiver to assist. Child receives a medical service at school on this date.

Check the appropriate column that indicates the degree to which the child's need for help in the completion of each task is met. Check one column for each task:

M = Met: The child's needs are met. The child may be independent in this task or someone other than the Personal Care Paraprofessional is meeting the child's need for help. Other sources for meeting the need include family or friends. No time can be authorized for any task coded with an "M".

P = Partially Met: The child requires help with the task. Someone other than the personal care paraprofessional is providing that help part of the time, or the child may participate in the task.

U = Unmet: The child requires help with the task and the need is currently unmet.

5. Notes: Enter any appropriate notes.
6. Minutes Per Day: For each task to be provided, enter the daily number of minutes needed to conduct that task.
7. Days Per Week: For each task to be provided, enter the number of days per week the child will require assistance with the task.
8. Total Minutes: Multiply the minutes per day times the days per week to obtain the total minutes per week for each task.

The amount of time allowed for any particular task should be determined by taking into account:

1. The amount of assistance the child will usually need
2. Which specific activities need to be accomplished
3. Environmental/housing factors that may hinder (or facilitate) service delivery
4. Child's unique circumstances

Personal Care Paraprofessional Services Provided In Schools

Child Profile - Form

Child Name:	Child ID:	DOB:
Date Span:		

Personal Care Activities of Daily Living Tasks

		I	N	Min/Day X Days/Week = Total minutes
1. Can child dress self?	Dressing	X		X =
2. Does child need assistance with an exercise program?	Exercise			X =
3. Can child groom self? (Wash, comb hair)	Grooming			X =
4. Does child have any difficulties getting to and using the bathroom?	Toileting			X =
5. Can child get in and out of their bed or chair?	Transferring			X =
6. Can child walk without help?	Ambulation			X =
Does child need assistance eating?	Eating			X =
7. Bus Escort	Escort			X =

I = Impairment 0 = Independent 1 = Cuing 2 = Limited Assistance 3 = Extensive Assistance 4 = Total Dependence	N = Need M = Met P = Partially Met U = Unmet	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Total</td> <td style="width: 50%; background-color: #cccccc;"></td> </tr> <tr> <td colspan="2">Total Minutes / 15 = _____ Total Units of Service/Week</td> </tr> <tr> <td colspan="2">Total Units of Service _____ / 4 = _____ Total Hours/Week</td> </tr> </table>	Total		Total Minutes / 15 = _____ Total Units of Service/Week		Total Units of Service _____ / 4 = _____ Total Hours/Week	
Total								
Total Minutes / 15 = _____ Total Units of Service/Week								
Total Units of Service _____ / 4 = _____ Total Hours/Week								

Comments:

Verbal Order Date: _____	Initial: _____
--------------------------	----------------

School: _____

School Representative Signature Date _____

Primary Care Provider Signature _____ Date _____

Passport Provider Number _____

Task/Hour Guide Instructions

Purpose

The purpose of this form is to record the amount of time that is spent providing Personal Care services. This form is a sample and can be recreated by district personnel to meet specific needs.

Specific Tasks

Each task has one or more activities or sub-tasks that forms the overall task. When calculating time, carefully consider which activities were provided.

1. Dressing:
 - Dressing recipient
 - Undressing recipient
 - Cuing assistance
2. Exercise:
 - Range of motion
3. Grooming:
 - Brushing teeth
 - Laying out supplies
 - Combing/brushing hair
 - Applying nonprescription lotion to skin
 - Washing hands and face
 - Cuing assistance
4. Toileting:
 - Changing diapers
 - Changing colostomy bag/emptying catheter bag
 - Assisting on/off bed pan
 - Assisting with use of urinal
 - Assisting with feminine hygiene needs
 - Assisting with clothing during toileting
 - Assisting with toilet hygiene: includes use of toilet paper & washing hands
 - Set-up supplies and equipment (Does NOT include preparing catheter equipment)
 - Standby assistance
5. Transfer:
 - Non-ambulatory movement from one stationary position to another (transfer)
 - Adjusting/changing recipient's position in bed or chair (positioning)
6. Ambulation (Walking):

- Assisting child in rising from a sitting to a standing position and/or position for use of walking apparatus
- Assisting with putting on and removing leg braces and prostheses for ambulation
- Assisting with ambulation/using steps
- Standby assistance with ambulation
- Assistance with wheelchair ambulation

NOTE: Do not include exercise as ambulation.

7. Eating:

- Spoon feeding
- Bottle feeding
- Set up of utensils/adaptive devices
- Assistance with using eating or drinking utensils/adaptive devices
- Cutting up foods
- Standby assistance/encouragement

NOTE: Tube feeding is not an allowable service.

8. Bus Escort:

- Accompanying a child on the bus when the child is functionally limited and receives medical service at the school on that date. Not for purposes of behavioral management.

Task/Hour Guide

Child Name:		Child ID:				
		Monday	Tuesday	Wednesday	Thursday	Friday
	Date					
Grooming						
Dressing Assistance						
Exercise						
Toileting						
Transfer Assistance						
Ambulation Assistance						
Eating Assistance						
Bus Escort						
Notes:						
Signature/Date						
		Monday	Tuesday	Wednesday	Thursday	Friday
	Date					
Grooming						
Dressing Assistance						
Exercise						
Toileting						
Transfer Assistance						
Ambulation Assistance						
Eating Assistance						
Bus Escort						
Notes:						
Signature/Date						

Appendix C: CSCT Program

- *CSCT Program Endorsement*
- *CSCT Program Audit Checklist*
- *Sample Certification of Match Statement*

CSCT Program Endorsement

Prior to CSCT program implementation, the mental health center must be licensed and have a CSCT endorsement issued by the Department of Public Health and Human Services. (See also the following rules: 37.86.2225, 37.106.1955, 37.106.1956, 37.106.1960, 37.106.1961 and 37.106.1965.)

1. The CSCT program must be able to provide the following services as needed, to children or adolescents with a serious emotional disturbance:
 - a. Individual, family and group therapy;
 - b. Behavior intervention;
 - c. Other evidence and research-based practices effective in the treatment of children or adolescents with a serious emotional disturbance;
 - d. Direct crisis intervention services during the time the child or adolescent is present in school;
 - e. Crisis intervention services by telephone during the time(s) the child or adolescent is not present in school;
 - f. Treatment plan coordination with addictive and mental health treatment services provided outside the CSCT program;
 - g. Access to emergency services;
 - h. Referral and aftercare coordination with inpatient facilities, residential treatment programs or other appropriate out-of-home placement programs; and
 - i. Continuous treatment that includes services during non-school days, integrated in a manner consistent with the child or adolescent's treatment plan.
2. The CSCT program must have written admission and discharge criteria.
3. The program must assess the needs of a child or adolescent with a serious emotional disturbance and the appropriateness of the CSCT program to meet those needs.
4. If the CSCT program utilizes time-out or aversive treatment procedures, there must be written procedures regarding the use of these procedures.
5. The CSCT services must be provided by two staff that consist of at least one licensed mental health professional (licensed psychologist, licensed social worker or licensed clinical professional counselor) and one non-licensed mental health aide.
6. Adequately trained staff must deliver services provided through the CSCT program. Training must be documented and maintained in the personnel files.
7. Services provided through the CSCT program must be adequately documented to support services billed to Medicaid.
8. The CSCT program must be coordinated with the child or adolescent's special education program, if any.

CSCT Program Audit Checklist

For the Comprehensive School and Community Treatment Program, school districts and cooperatives retain responsibility for ensuring that all program requirements are met. School districts/cooperatives may not be in compliance if any statement below is checked “No.”

Program Endorsement – The school district/cooperative or the licensed mental health center with whom the district/cooperative is contracting must have a CSCT endorsement from the Montana DPHHS. CSCT providers must follow the Administrative Rules of Montana and the policy manual related to these services as set forth by the Department of Public Health and Human Services (DPHHS).			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Has the school district/cooperative identified a primary contact person at the mental health center that is providing the CSCT program services?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Does the school district/cooperative or the mental health center have a CSCT endorsement from the Montana DPHHS?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Does the school district/cooperative have a signed contract with the mental health center that provides CSCT services?
Service/Billing Documentation – Services provided through the CSCT program must be documented in the same manner as all other services included in the Montana School-Based Services Program. The only exception is that services in this program can be provided to students both with or without special education needs or without services being included on a student’s IEP.			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is an individual treatment plan in place to provide CSCT services for each student?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is the billing documentation accurate for services performed (including student name, date of service, duration of service, type of service and notes that show progress toward student goals)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Does CSCT program staff keep daily detailed records on services provided through the program?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Does the CSCT program staff keep overall monthly progress notes?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Does the CSCT program staff track individual outcomes compared to baseline measures and established benchmarks?

Certification of Match – School districts/cooperatives are responsible for certifying non-federal match for services provided to students who do not have CSCT services included on their IEPs.			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Does the school district/cooperative maintain documentation of costs incurred by the CSCT program?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Are the documented costs greater than the Medicaid funding provided (by at least the amount required for certification of match)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Can the school district/cooperative demonstrate that there are enough state/local funds being

CSCT Program Audit Checklist

			expended by the district that: <ul style="list-style-type: none"> • Are not used to match other federal funds being received, • Are not IDEA funds or state special education funds, and • Are not Medicaid dollars?
___ Yes	___ No	___ N/A	Has the school district/cooperative maintained a budget or work papers that verify the certification of match documentation?
Free Care Rule – For CSCT programs that are providing services to students with serious emotional disturbances who do not have services documented on the IEP the school district/cooperative must ensure that they are following the free care rule.			
___ Yes	___ No	___ N/A	Is the CSCT program offered to students based on service needs, regardless of the students' Medicaid eligibility status?
___ Yes	___ No	___ N/A	If the school district/cooperative provides services to students who do not have CSCT services included on the IEP, has a sliding scale been developed for CSCT services?
___ Yes	___ No	___ N/A	Has the school district/cooperative identified all third parties that may be financially responsible for services provided that are not included in a student's IEP?
___ Yes	___ No	___ N/A	Has the CSCT program billed the third parties that are financially responsible for services, including the students' insurers or their parents?
Program Documentation – The school district/cooperative must have access to any CSCT program records that may be audited.			
___ Yes	___ No	___ N/A	Has the school district/cooperative developed a program area for CSCT in the accounting system?
___ Yes	___ No	___ N/A	Has the school district/cooperative booked revenues and expenditures for the CSCT program?
___ Yes	___ No	___ N/A	Is documentation retained for a period of six years and three months from the date of service?
___ Yes	___ No	___ N/A	Are all service documentation records available at a central district location or available for audit?

Sample Certification of Match Statement

This statement is provided annually by DPHHS and must be returned to verify certification of local and state expenditures to support the federal match.

Montana Department of Public Health and Human Services
Health Resources Division
P.O. Box 202951
Helena, MT 59620 - 2951

RE: Annual Certification of State and Local Expenditures

Dear _____:

I, as financial officer of the _____ School District/Cooperative, am charged with the duties of supervising the administration of the provision and billing for the Comprehensive School and Community Treatment (CSCT) Services provided under Title XIX (Medicaid) of the Social Security Act, as amended. I hereby certify that the school district has expended the state and local share of public, non-federal funds needed to match the federal share of medical claims billed to the state Medicaid agency for School District CSCT services provided to eligible children during the _____ school year.

1. DPHHS has completed calculation of reimbursement for CSCT services for the year_____.
2. The amount paid by DPHHS for CSCT services is _____.
3. The state and local expenditures that are required to support a certification of match is, _____ . (Medicaid payment for CSCT Services / Current FMAP Rate X Current State Match Rate = Local District Match)

____ These certified expenditures are separately identified and supported in our accounting system, or
____ Sufficient State and local revenues are available to meet or exceed the match.

I certify that the school district/cooperative's state and local expenditures (shown in # 3 above) were incurred in accordance with provisions of Montana's policies. These certified expenditures are separately identified and supported in our accounting system.

Name (please print): _____

Signature: _____

Title: _____

School District or Cooperative: _____

Date: _____

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions

The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions

The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions

The ASC X12N request for services review and response used for prior authorization.

835 Transactions

The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions

The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)

The ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Administrative Rules of Montana (ARM)

The rules published by the executive departments and agencies of the state government.

Allowed Amount

The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, (such as cost sharing, TPL, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Ancillary Provider

Any provider that is subordinate to the client's primary provider, or providing services in the facility or institution that has accepted the client as a Medicaid client.

Assignment of Benefits

A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization

An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid

Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Bundled

Items or services that are deemed integral to performing a procedure or visit are not paid separately in the APC system. They are packaged (also called bundled) into the payment for the procedure or visit. Medicare developed the relative weights for surgical, medical and other types of visits so that the weights reflect the packaging rules used in the APC method. Items or services that are packaged receive a status code of “N”.

Cash Option

Cash option allows the client to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than a partial month.

Centers for Medicare and Medicaid Services (CMS)

Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Children’s Health Insurance Plan (CHIP)

This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

Children’s Special Health Services (CSHS)

CSHS assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Clean Claim

A claim that can be processed without additional information from or action by the provider of the service.

Client

An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)

Rules published by executive departments and agencies of the federal government.

Coinsurance

The client’s financial responsibility for a medical bill as assigned by Medicaid or Medicare (usually a percentage). Medicaid coinsurance is usually 5% of the Medicaid allowed amount, and Medicare coinsurance is usually 20% of the Medicare allowed amount.

Conversion Factor

A state specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Copayment

The client’s financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic

Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing

The client’s financial responsibility for a medical bill, usually in the form of a copayment (flat fee) or coinsurance (percentage of charges).

CPT-4

Physicians’ *Current Procedural Terminology, Fourth Edition*. This book contains procedure codes which are used by medical practitioners in billing for services rendered. The book is published by the American Medical Association.

Credit Balance Claims

Adjusted claims that reduce original payments, causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the remittance advice until the credit has been satisfied.

Crossovers

Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency

The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles

Clients who are covered by Medicare and Medicaid are often referred to as “dual eligibles.”

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Electronic Funds Transfer (EFT)

Payment of medical claims that are deposited directly to the provider's bank account.

Emergency Services

Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity

(including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Experimental

A non-covered item or service that researchers are studying to investigate how it affects health.

Explanation of Medicare Benefits (EOMB)

A notice sent to providers informing them of the services which have been paid by Medicare.

Fiscal Agent

ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Free Care Rule

If a service is free to non-Medicaid clients, then it must also be free to Medicaid clients. Medicaid cannot be billed for services that are provided free to non-Medicaid clients.

Full Medicaid

Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment

A lump sum debit or credit that is not claim specific made to a provider.

HCPCS

Acronym for the Healthcare Common Procedure Coding System, and is pronounced “hick-picks.” There are three types of HCPCS codes:

- Level 1 includes the CPT-4 codes.
- Level 2 includes the alphanumeric codes A - V which CMS maintains for a wide range of services from ambulance trips to hearing aids which are not addressed by CPT-4 coding.

Health Insurance Portability and Accountability Act (HIPAA)

A federal plan designed to improve efficiency of the health care system by establishing standards for transmission, storage, and handling of data.

ICD-9-CM

The International Classification of Diseases, 9th Revision, Clinical Modification. This is a three volume set of books which contains the diagnosis codes used in coding claims, as well as the procedure codes used in billing for services performed in a hospital setting.

Indian Health Service (IHS)

IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment

A request for a correction to a specific paid claim.

Internal Control Number (ICN)

The unique number assigned to each claim transaction that is used for tracking.

Investigational

A non-covered item or service that researchers are studying to investigate how it affects health.

Kiosk

A “room” or area in the Montana Virtual Human Services Pavilion (VHSP) website that contains information on the topic specified.

Mass Adjustment

Request for a correction to a group of claims meeting specific defined criteria.

Medicaid

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medicaid Eligibility and Payment System (MEPS)

A computer system by which providers may access a client’s eligibility, demographic, and claim status history information via the internet.

Medically Necessary

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, “course of treatment” may include mere observation or, when appropriate, no treatment at all.

Medicare

The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)

This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Mentally Incompetent

According to CFR 441.251, a mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Montana Breast and Cervical Cancer Treatment Program

This program provides Basic Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition.

PASSPORT Authorization Number

When a PASSPORT provider refers a client to another provider for services, this number is given to the other provider and is required when processing the claim.

PASSPORT To Health

A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Pay and Chase

Medicaid pays a claim and then recovers payment from the third party carrier that is financially responsible for all or part of the claim.

Pending Claim

These claims have been entered into the system, but have not reached final disposition. They require either additional review or are waiting for client eligibility information.

Potential Third Party Liability

Any entity that may be liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Prior Authorization (PA)

The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay

When a client chooses to pay for medical services out of his or her own pocket.

Protocols

Written plans developed by a public health clinic in collaboration with physician and nursing staff. Protocols specify nursing procedures to be followed in giving a specific exam, or providing care for particular conditions. Protocols must be updated and approved by a physician at least annually.

Provider or Provider of Service

An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)

QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Reason and Remark Code

A code which prints on the Medicaid remittance advice (RA) that explains why a claim was denied or suspended. The explanation of the Reason/Remark codes is found at the end of the RA (formerly called EOB code).

Referral

When providers refer clients to other Medicaid providers for medically necessary services that the PASSPORT provider does not provide.

Remittance Advice (RA)

The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Resource-Based Relative Value Scale (RBRVS)

A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

Retroactive Eligibility

When a client is determined to be eligible for Medicaid effective prior to the current date.

Sanction

The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

School-Based Services

Medically necessary health-related services provided to Medicaid eligible children up to and including age 20. These services are provided in a school setting by licensed medical professionals.

Specified Low-Income Medicare Beneficiaries (SLMB)

For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down

Clients with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Team Care

A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a "team" consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)

Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing

Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
 - the date of service
 - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary

The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)

This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. <http://vhsp.dphhs.state.mt.us>

WINASAP 2003

WINASAP 2003 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information contact ACE EDI Gateway (see *Key Contacts*).

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